

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 4 2 6 8			
FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Richard Patrick Ambush				2a. DATE OF DEATH September 29 1980		2b. HOUR 7:45 AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH 4 19 28		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Fred. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) IRON & STEEL		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Charles H Ambush		15. MOTHER'S MAIDEN NAME Emma Bruce		16. STREET ADDRESS 229 Center St.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. W.W.H.		17. INFORMANT ADDRESS Frederick, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few minutes					
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) DUE TO, OR AS A CONSEQUENCE OF Brain metastasis		6 months			
		(c) DUE TO, OR AS A CONSEQUENCE OF Bronchogenic Ca					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION n/a		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8-19-80, 19_____, to 9-29-80, 19_____, that (I) (we) lost saw the deceased alive on 9-29-80, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. F. Abdullah, M. D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-30-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. F. Abdullah, M. D.				22e. ADDRESS 318 N. Potomac St. Hagerstown, Md. 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-2-1980		23c. NAME OF CEMETERY OR CREMATORY Rest Haven m. Home		23d. LOCATION CITY OR TOWN COUNTY STATE RT 15 Frederick, Md.	
24. FUNERAL DIRECTOR NAME C. E. HICKS		24b. ADDRESS 263 W. PATRICK ST		25a. DATE REG'D. BY REGISTRAR 0612 1980		25b. REGISTRAR'S SIGNATURE	

BP _____

[Faint handwritten notes at the bottom of the page, possibly "L. J. ..."]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	2	4	2	6	9	
FOR STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Barbara Lee ANDERSON										2a. DATE OF DEATH MONTH DAY YEAR Sept. 7, 1980				2b. HOUR M			
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Sept. 17, 1935			6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.								
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) baker			12b. KIND OF BUSINESS OR INDUSTRY confectionary					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland										13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 349 West Side Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST William E. Thurston					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred T. Hottle												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-34-3742		17. INFORMANT ADDRESS Mr. Stanley L. Anderson, Hagerstown, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO RESP. ARREST</u> 1991 DUE TO, OR AS A CONSEQUENCE OF (b) <u>MESENTERIC CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I, (this hospital) attended the deceased from <u>9/6/80</u> 19 <u>80</u> , to <u>9/6/80</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>9/6/80</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <u>L. Dwight Wooster</u> M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. Dwight Wooster, M. D.					22e. ADDRESS 1825 Howell Rd., Hagerstown, Md. 21740												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 9, 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Memorial			23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland									
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd. Hagerstown, Maryland 21740					25a. DATE REC'D. BY REGISTRAR SEP 15 1980			25b. REGISTRAR'S SIGNATURE <u>Ricky Reddy</u>									

U.S. AIR FORCE

OFFICE OF THE
DIRECTOR, AIR FORCE
RESEARCH AND DEVELOPMENT

[Faint, mostly illegible text and markings covering the main body of the document, possibly bleed-through from the reverse side.]

Approved: _____ Date: _____

SEP 15 1960



FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 4 2 7 0

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Bernard Alonza Andrews			2a. DATE OF DEATH MONTH DAY YEAR Sept. 13 1980			2b. HOUR 11:15 PM				
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Dec 14 1935		6 AGE (IN YEARS LAST BIRTHDAY) 44 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 39 W. Bethel St.	
14. FATHER'S NAME FIRST MIDDLE LAST Lewis NMN Bandy			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace NMN Andrews							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean		17 INFORMANT Rosetta Andrews			ADDRESS 39 W. Bethel St.		

11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic encephalopathy</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>embolic liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1975	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>gastrointestinal bleeding</u>			
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1977</u> 19 <u>80</u> to <u>Sept</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>Sept. 13</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Gloria F. Pura</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GLORIA F. PURA</u>		22e. ADDRESS <u>382 S. CLEVELAND HAGER</u>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/18/80		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md.	
24 FUNERAL DIRECTOR NAME <u>Hennie L. Harris Smithburg, Md.</u>				25a. DATE OF DEATH SEP 17 1980		25b. REGISTERING SIGNATURE	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0

2 4 2 7 1

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Fannie L. ASHCAM			2a. DATE OF DEATH MONTH DAY YEAR September 12, 1980		2b. HOUR MIN. 10:30A	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 17, 1881		6. AGE (IN YEARS LAST BIRTHDAY) 98	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kyser, W. Va.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education
13a. STATE Maryland			13b. CITY OR TOWN Baltimore	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 3939 Roland Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST George Edwin Leps			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Ann Athey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-74-8040		17. INFORMANT ADDRESS Rfd. 1 Box 118 Mrs. Elizabeth L. Toms, Boonsboro, Md. 2171		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cerebrovascular accident						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I, his hospital) attended the deceased from Aug 19, 1980 to Sept 12, 1980 that (I) (we) lost saw the deceased live on Sept 12, 1980 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (Do not check if did not view the body after death.)						
22b. SIGNATURE Robert Bruhl		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/12/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Bruhl, MD		22e. ADDRESS 1198 Kenly Ave. Hagerstown, Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9-13-80		23c. NAME OF CEMETERY OR CREMATORY Loudan Park Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Balt. Co., Md.
24. FUNERAL DIRECTOR NAME ADDRESS John H. Bast, Jr. Boonsboro, Md. 21713				25a. DATE REC'D. BY REGISTRAR SEP 15 1980		25b. REGISTRAR'S SIGNATURE Anthony McCreedy

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MEDICAL CERTIFICATION

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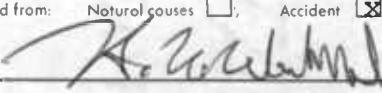
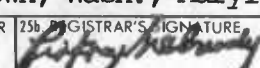
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER MUST SIGN AND DATE THE BOTTOM OF THIS CERTIFICATE. PAGES 1, 2, AND 3 TO THE FUNERAL HOME MUST BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3. RETAIN PAGE 4. SHOULD BE FILED WITHIN 72 HOURS OF DEATH.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS OF DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRINCESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M7/77

STATE OF MARYLAND										00		24272			
DEPARTMENT OF HEALTH AND MENTAL HYGIENE															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Richard Vernon BARGER, III										2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/>		MONTH DAY YEAR September 13 1980		2b. HOUR 12:30 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 10, 1956		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 24		IF UNDER 1 YR. MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN. 0 0		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR September 13 1980		2d. HOUR 12:30 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) painter				12b. KIND OF BUSINESS OR INDUSTRY painting cont			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 614 Hayes Avenue			
14. FATHER'S NAME (FIRST) MIDDLE LAST Richard V. Barger, Sr.										15. MOTHER'S MAIDEN NAME (FIRST) MIDDLE LAST Peggy Barnhart					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS Mrs. Peggy B. Barger, Hagerstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) Code E-814 (Pedestrian hit by motor vehicle) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR 11 P.M. Sept. 12, 80				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Struck by car on highway							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Highway				21f. LOCATION STREET CITY OR TOWN COUNTY STATE U.S. Rt. 40 West of Hagerstown, Wash. Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER						DATE SIGNED 9/15/80					
EXAMINER'S NAME (TYPE OR PRINT) Howard N. Weeks, M.D.				ADDRESS 580 Northern Avenue Hagerstown, Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Sept. 16, 1980		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740										25a. DATE REC'D. BY REGISTRAR SEP 18 1980		25b. REGISTRAR'S SIGNATURE 			

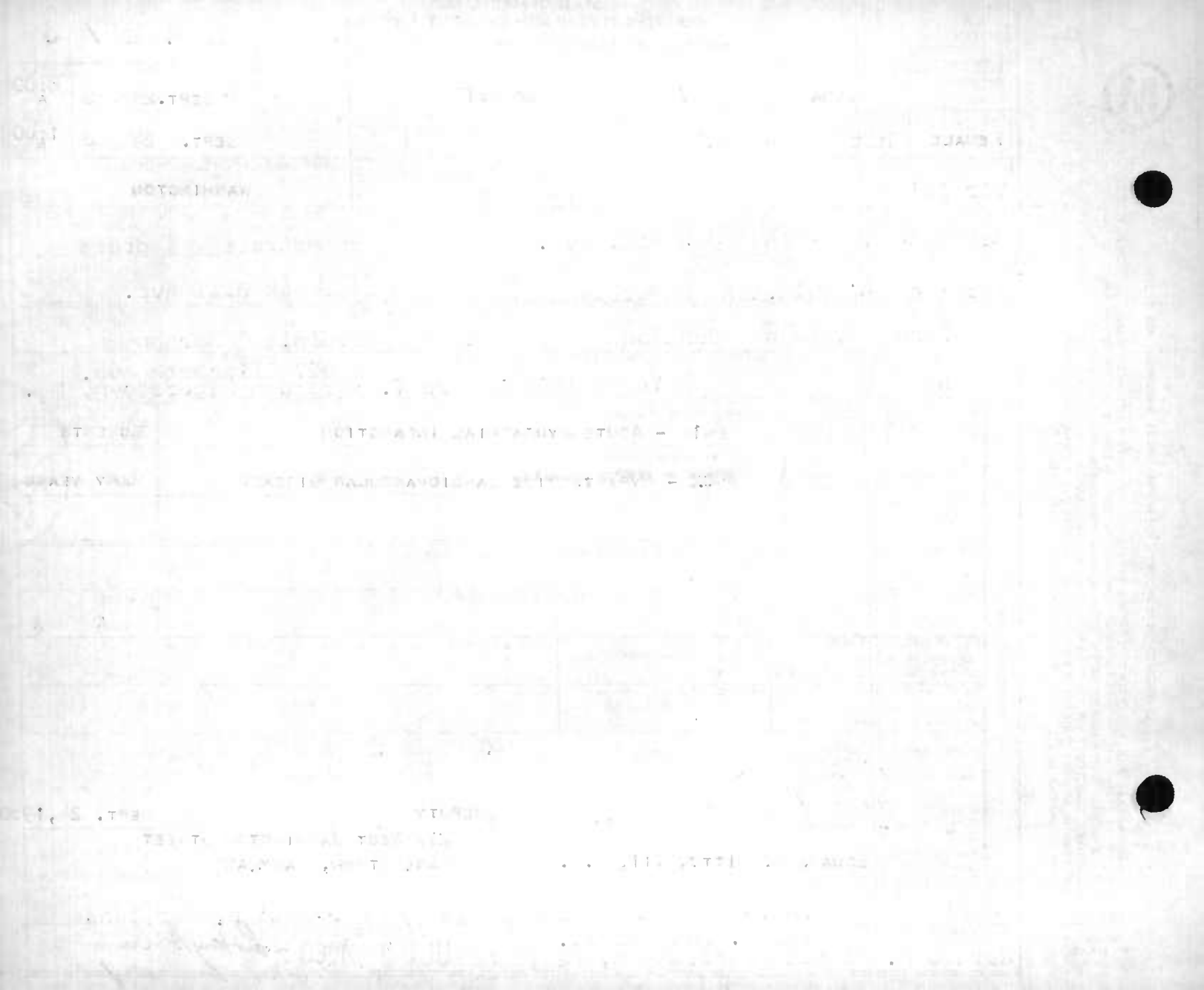


SEP 10 1960

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMM - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 24273					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDNA V BARNETT										2a. DATE KNOWN OF DEATH MONTH DAY YEAR SEPT. 24 19 80		2b. HOUR 8:00 A M			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5-11-03		6. AGE (IN YEARS) LAST BIRTHDAY 77 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR SEPT. 24 19 80		2d. HOUR 1:00 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.			
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1601 Oak Hill Ave.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) seamstress				12b. KIND OF BUSINESS OR INDUSTRY dress	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1601 Oak Hill Ave.							
14. FATHER'S NAME FIRST MIDDLE LAST John Calvin Johnson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Virginia Morgan									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 214 09 1771		17. INFORMANT ADDRESS 327 Elizabeth Ave. Edward T. Harbaugh Hagerstown, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) #414 - ACUTE MYOCARDIAL INFARCTION 410 - Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) #402 - HYPERTENSIVE CARDIOVASCULAR DISEASE (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MOMENTS MANY YEARS															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Edward W. Ditto III				TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER				DATE SIGNED SEPT. 24, 1980							
EXAMINER'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.				ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9-27-80		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Maryland					
24. FUNERAL DIRECTOR NAME Gerald N. Minnich				ADDRESS 305 N. Potomac St. Hagerstown, Maryland				25a. DATE REC'D. BY REGISTRAR OCT 2 1980		25b. REGISTRAR'S SIGNATURE [Signature]					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	2	4	2	7	4		
1- FOR STATE REGISTRAR										CERTIFICATE OF DEATH								
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH				2b. HOUR				
Ray C. Barnhart										September 8, 1980				5:30 P ^M				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
male			white			8/3/1913			67			MONTHS		DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Penna.			U.S.A.						Washington Co. MD.									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown			Washington Co Hospital							Trucker			Hauling					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS						
13a. STATE 13b. COUNTY 13c. CITY OR TOWN										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2527 Paradise Church Road						
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME								
W Leslie Barnhart										A. Blanche Pittman								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS						
no										214-09-3678		Emma Barnhart 2527 Paradise Church Rd						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY																		
IMMEDIATE CAUSE (a) Cardio-Pulmonary arrest																		
4292 DUE TO, OR AS A CONSEQUENCE OF																		
(b) Atherosclerotic Cardiovascular Disease																		
DUE TO, OR AS A CONSEQUENCE OF																		
(c) Congestive Heart Failure																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																		
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
													YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
										HOUR A.M. MONTH DAY YEAR								
										P.M. 19								
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK													CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from Aug 29, 1980, to Sept 8, 1980, that (I) (we) last saw the deceased alive on Sept 8, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
										Eric M. Wagshal MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			9-8-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS								
Dr. Eric M. Wagshal										1825 Howell Rd Hagerstown, Md								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
Burial										9/11/1980		Rest Haven Cemetery			Hagerstown, Washington, Md			
24. FUNERAL DIRECTOR										25. DATE REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Dwain M. Zimmerman										SEP 15 1980			Dwain M. Zimmerman					

TO HOSPITAL OR ATTENDING PHYSICIAN: The information obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 2 4 2 7 5	
1- STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Virginia Mae Mary BARNHART					2a. DATE OF DEATH MONTH DAY YEAR September 14 1980			2b. HOUR 3:15P M			
3 SEX Female		4 RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR May 1, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD					
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Garment			
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hancock		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 210 Myers Street	
14. FATHER'S NAME FIRST MIDDLE LAST Richard R. Bishop					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie E. Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 05 7422		17 INFORMANT Edward L. Barnhart			ADDRESS same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 410 - DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ACUTE RENAL FAILURE											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Eli Roga					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-19-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-18-80		23c. NAME OF CEMETERY OR CREMATORY Parkhead Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Big Pool Wash. Md			
24. FUNERAL DIRECTOR NAME Richard J. Shaw					ADDRESS Hancock MD		25a. DATE REC'D. BY REGISTRAR SEP 24 1980		25b. REGISTRAR'S SIGNATURE [Signature]		

SECRET
NO FORN DISSEM
EXCLUDED FROM AUTOMATIC
DOWNGRADING AND
DECLASSIFICATION



2025 JAN

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

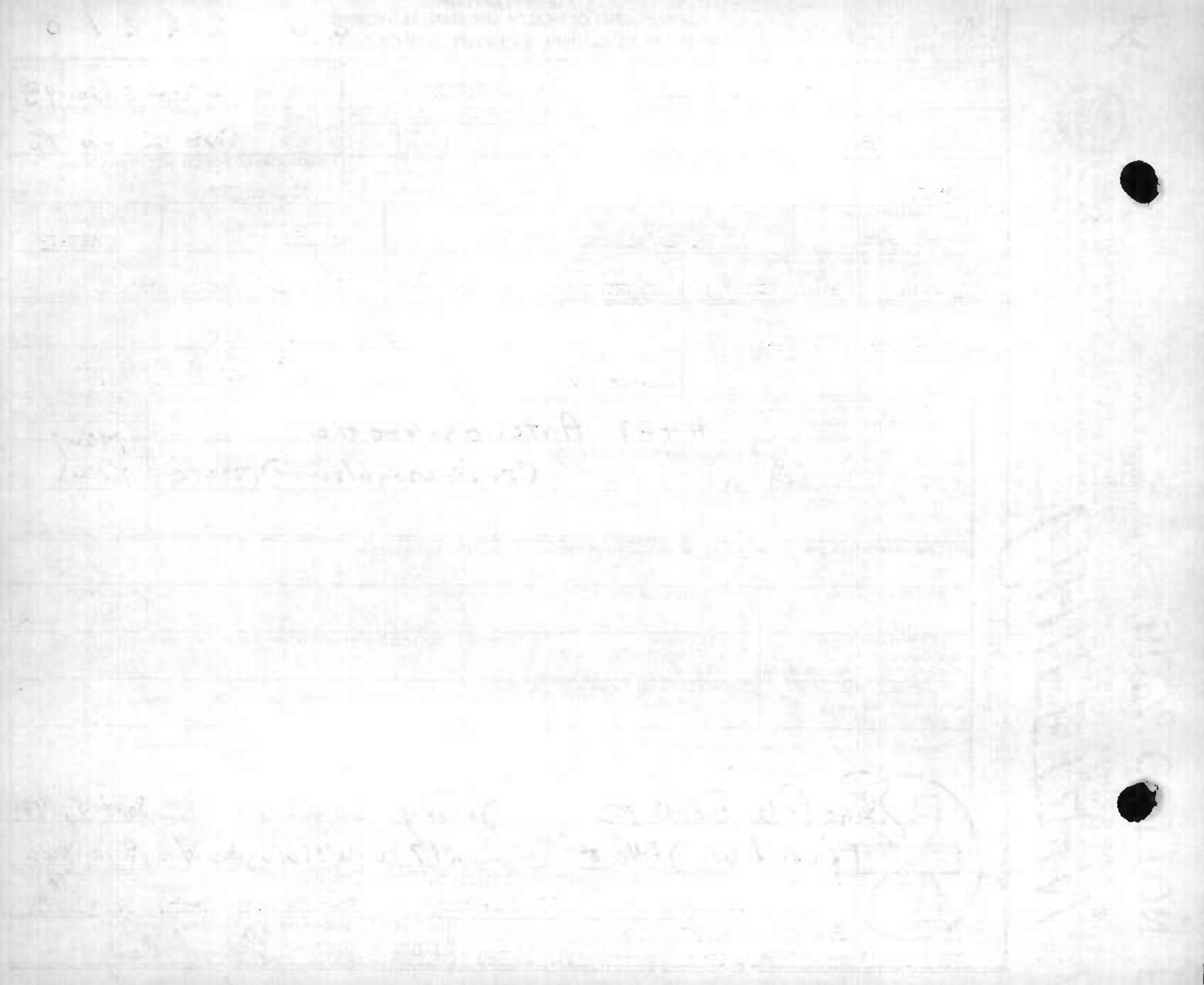
DMMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			2b. HOUR		
Elva Elizabeth BARNHILL						Sept 2 1980			9:00 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			7d. HOUR		
female	white	May 2, 1891	89 YRS.			Sept 2 1980			7:00 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			USA						Washington MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			11 W. Baltimore Street			clerk			laundry		
13a. STATE			13b. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Maryland			Washington			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			11 W. Baltimore Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
Harry R. Harbaugh			Martha E. Brown			No			215-34-3407		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
Martha L. Koerner, Hagerstown, Md.			PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) #429 Arteriosclerotic 4292 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Cardiovascular Disease (c) DUE TO, OR AS A CONSEQUENCE OF						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED Sept 5, 1980		
ACTUAL SIGNATURE Edward W. Dittmer			EXAMINER'S NAME (TYPE OR PRINT) Edward W. Dittmer			ADDRESS 217 W. Washington St. Hagerstown					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
burial			Sept. 5, 1980			Rose Hill Cemetery			Hagerstown, Wash., Maryland		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
MINNICH FUNERAL HOME			SEP - 9 1980			R. J. McCreedy					
415 E. Wilson Blvd., Hagerstown, Md. 21740											



TO HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 4 2 7 7	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Charles Elmer Beachley					2a. DATE OF DEATH MONTH DAY YEAR Sept 6, 1980			2b. HOUR 8:00 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 28, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 82		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Frederick Co., Md		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY State Roads Dept.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro		13e. STREET ADDRESS Rfd. 3 Box 528					
14. FATHER'S NAME FIRST MIDDLE LAST Charles Beachley					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Easterday						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-36-8293		17. INFORMANT ADDRESS Rfd. 3 Box 528 Boonsboro, Md. 21713							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain stem cerebrovascular accident 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9-6 19 80 , to 9-6 19 80 , that (I) (we) last saw the deceased alive on 9-6 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles C. Spencer				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-6-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles C. Spencer, M. D.				22e. ADDRESS 1198 Kenly Ave., Hagerstown, Md. 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-10-80		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Boonsboro, Wash. Co., Md.					
24. FUNERAL DIRECTOR John H. Bast, Jr.				ADDRESS Boonsboro, Md. 21713		25a. DATE REC'D. BY REGISTRAR SEP 10 1980		25b. REGISTRAR'S SIGNATURE Dickie McCreedy			

1790 Kelly Ave., Westport, N.Y. 11580
 Charles A. Spencer, Jr.
 2-11-55 Westport Community
 John A. Kelly, Jr. Westport, N.Y. 11580

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 John A. Kelly, Jr. Westport, N.Y. 11580

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M/7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 4 2 7 8

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR		
Lyle Edward Beitz						Sept 3 1980			6:00 PM					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR		
Male	White	Sept. 5, 1940	39 YRS.			Sept 5 1980			7:00 PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia			U.S.A.						Washington County, MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Williamsport			2 mi. west Williamsport			Utility			Corning Glass					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
W. Va.				Berkeley		Martinsburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1403 No. Queen Street				
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME										
Jesse Beitz				Neta Hendricks										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.		17. INFORMANT								
No				236-62-6329		Rose Marie Beitz-Martinsburg, W. Va. 25401								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>N-994 Drowning</u>													11 months	
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF														
DUE TO, OR AS A CONSEQUENCE OF														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?		
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
6:00 P.M. Sept 3 1980				Drowned while swimming in Potomac River										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION						
River				2 mi. west Williamsport Wash. MD										
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED						
Edward W. Dittus III				M.D. Deputy				Sept 5, 1980						
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS										
Edward W. Dittus III				211 W. Washington St - Hagerstown, MD										
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				
Burial				9-8-80		Pleasant View Memory Gardens Martinsburg Berkeley WV								
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
Charles M. Brown				SEP - 9 1980				Pottery McBrady						
Brown Funeral Home, Inc. Martinsburg, W.V. 25401														

1947

Style	Quantity	Notes
White	100	
Black	100	
Grey	100	
Blue	100	
Green	100	
Yellow	100	
Orange	100	
Pink	100	
Brown	100	
Red	100	
White	100	
Black	100	
Grey	100	
Blue	100	
Green	100	
Yellow	100	
Orange	100	
Pink	100	
Brown	100	
Red	100	

Handwritten notes:

1. 100 White

2. 100 Black

3. 100 Grey

4. 100 Blue

5. 100 Green

6. 100 Yellow

7. 100 Orange

8. 100 Pink

9. 100 Brown

10. 100 Red

11. 100 White

12. 100 Black

13. 100 Grey

14. 100 Blue

15. 100 Green

16. 100 Yellow

17. 100 Orange

18. 100 Pink

19. 100 Brown

20. 100 Red

2

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 24279	
1. DECEASED NAME (TYPE OR PRINT) William Thomas Bell, II										20. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR Sept 5 1980	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Apr. DAY 7. YEAR 1957	6. AGE (IN YEARS LAST BIRTHDAY) 23 YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	21. DATE PRONOUNCED DEAD Sept 5 1980		22. HOUR 12:30 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington		MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber		12b. KIND OF BUSINESS OR INDUSTRY Plumbing			
13a. STATE Virginia		13b. COUNTY Washington		13c. CITY OR TOWN Bluemont		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. Box 245			
14. FATHER'S NAME FIRST William Thomas Bell, Sr. MIDDLE Bell LAST Sr.				15. MOTHER'S MAIDEN NAME FIRST Naomi MIDDLE Furr LAST Furr							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 226-86-0964		17. INFORMANT Peggy F. Bell		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) E-815 Motor Vehicle Fixed Object DUE TO, OR AS A CONSEQUENCE OF Collision Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) (Fr - Polys - Laceration Kidney, Liver, Spleen) DUE TO, OR AS A CONSEQUENCE OF Gunshot Wound (c) Gunshot Wound PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO A TERMINAL ILLNESS OR CONDITION GIVEN IN PART I Gunshot Wound										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 Min.	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 12:30 Sept 5 1980				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:30 Sept 5 1980				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Passover in Vehicle - Struck tree			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Highway				21f. LOCATION STREET Rt 464 CITY OR TOWN 3 Mi. Brunswick COUNTY Fred STATE MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Edward W. Ditto III				TITLE (SPECIFY) Deputy				DATE SIGNED Sept 5, 1980			
EXAMINER'S NAME (TYPE OR PRINT) Edward W. Ditto III, MD				ADDRESS 212 W. Washington St - Hagerstown, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Sept 10, 80		23c. NAME OF CEMETERY OR CREMATORY Leesburg Union		23d. LOCATION CITY OR TOWN Leesburg COUNTY Leesburg STATE VA			
24. FUNERAL DIRECTOR NAME Muse & Reed ADDRESS Leesburg, Virginia 22075				25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 4 2 8 0	
FOR 1. STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ROMAINE A. BERRY			2a. DATE OF DEATH MONTH 9 - DAY 1 YEAR 1980		2b. HOUR 3:37 A.M.
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH JAN. DAY 8 YEAR 1911		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS	# UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.	
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON CO. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY -
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE PA. 13b. COUNTY FRANKLIN 13c. CITY OR TOWN CHAMBERSBURG			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST WILLIAM MIDDLE E. LAST FORD			15. MOTHER'S MAIDEN NAME FIRST JENNIE MIDDLE STONER LAST 		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 174-20-8664		17. INFORMANT ADDRESS DAVID A. FORD, 191 COLUMBIA ST. STEELTON, PA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) CARDIOPATHY OF PANCREAS WITH DUE TO, OR AS A CONSEQUENCE OF METASTASIS TO LIVER (b) DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): RENAL FAILURE - DIABETES MELLITUS					
19a. DATE OF OPERATION 8-30-80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ABDOMINAL MASS		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-28 , 19 80 , to 8-31 , 19 80 , that (I) (we) last saw the deceased alive on 8-31 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-1-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OTTO ROZA MD		22e. ADDRESS 100 LONG MEADOW DRIVE HAGERSTOWN.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9-4-80		23c. NAME OF CEMETERY OR CREMATORY GETTYSBURG NATIONAL	
23d. LOCATION CITY OR TOWN GETTYSBURG COUNTY ADAMS STATE PA.		23e. DATE REC'D. BY REGISTRAR SEP 8 1980 23f. REGISTRAR'S SIGNATURE [Signature]			
24. FUNERAL DIRECTOR NAME Robert G. Sellers Funeral Home Inc.		24b. ADDRESS 297 Phila. Ave. Chambersburg, Pa. 17201			





BP

DHMH - 16 60M 7/73
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR <i>Battie Lee</i>									
1. DECEASED NAME (TYPE OR PRINT) <i>Bowers</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>September 14, 1980</i>				
3 SEX <i>Female</i>					2b. HOUR <i>1:15P</i>				
4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>July 10, 1895</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>85</i>			IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Luray, Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.			
10. CITY OR TOWN OF DEATH <i>Williamsport</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN WHICH FACILITY, GIVE STREET ADDRESS) <i>Williamsport Nursing Home</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Williamsport</i>		13e. STREET ADDRESS <i>Rd. 3</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Wilbur Skelton</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Davis</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>219-20-1424</i>		17. INFORMANT ADDRESS <i>Rd. 3</i> <i>Mr. Martha E. Martin, Williamsport, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerosis</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>8-7-80</i> to <i>9-14-80</i> , that (I) (we) lost <i>the deceased</i> on <i>8-7-80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Melnick</i> DEGREE					22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John R. Melnick, M.D.</i>					22e. ADDRESS <i>16220 Frederick Rd Gaithersburg MD 20760</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9-17-80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greenlawn Memorial Park</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Williamsport, Wash. Co., Md.</i>		
24. FUNERAL DIRECTOR NAME <i>John H. Bast, Jr.</i> ADDRESS <i>Boonsboro, Md. 21713</i>					25a. DATE REC'D. BY REGISTRAR <i>SEP 18 1980</i>		25b. SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	2	4	2	8	2
FOR 1- STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <u>Harold F Brown</u>										2a. DATE OF DEATH MONTH <u>September</u> DAY <u>24</u> YEAR <u>1980</u>				2b. HOUR <u>8:25</u> A.M.		
3. SEX <u>Male</u>			4. RACE <u>White</u>			5. DATE OF BIRTH MONTH <u>June</u> DAY <u>9</u> YEAR <u>1907</u>			6. AGE (IN YEARS LAST BIRTHDAY) <u>73</u> YRS.			IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>		IF UNDER 24 HRS HOURS <u> </u> MIN <u> </u>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington County, MD.</u>							
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>6 Spring Valley Drive</u>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Sales</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Publishing</u>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <u>Maryland</u> 13b. COUNTY <u>Washington</u> 13c. CITY OR TOWN <u>Hagerstown</u>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>6 Spring Valley Drive</u>				
14. FATHER'S NAME FIRST <u>Charles</u> MIDDLE <u>E.</u> LAST <u>Brown</u>					15. MOTHER'S MAIDEN NAME FIRST <u>Arbelin</u> MIDDLE <u> </u> LAST <u>Kinna</u>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>					16b. SOCIAL SECURITY NO. <u>082-05-4734</u>			17. INFORMANT ADDRESS <u>Mrs. Lenora Brown, 6 Spring Valley Dr</u>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable acute myocardial infarction</u> <u>410 -</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST <u>10 years</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus</u>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u> </u> <u> </u> <u>19</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (1) this hospital attended the deceased from <u>May 11</u> 19 <u>78</u> , to <u>Sept 24</u> 19 <u>80</u> , that (1) (we) lost saw the deceased alive on <u>Sept 23</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>Richard E. Smith, M.D.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <u>9/25/80</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Richard E. Smith, MD</u>					22e. ADDRESS <u>1708 Oak Hill Ave. Hagerstown, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>			23b. DATE <u>9-25-80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Crematory</u>			23d. LOCATION CITY OR TOWN <u>Smithsburg</u> COUNTY <u>Wash.</u> STATE <u>Md.</u>								
24. FUNERAL DIRECTOR NAME <u>Rest Haven Funeral Chapel, Inc., Hag.</u> ADDRESS <u> </u>					25a. DATE REC'D. BY REGISTRAR <u>SEP 29 1980</u>			25b. REGISTRAR'S SIGNATURE <u>W. J. McCreedy</u>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

33-108-101-2

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 4 2 8 3			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Helen Catherine BUXTON				2a. DATE OF DEATH MONTH DAY YEAR September 23, 1980			
3 SEX Female				2b. HOUR P M 1:10 P M			
4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 19 1906		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10 CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Readers Memorial Home		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY - - - - -			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. CITY OR TOWN Frederick			
14. FATHER'S NAME FIRST MIDDLE LAST William D. Curfman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ora VanFossen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - - - - - 214-16-1727			
17. INFORMANT ADDRESS Mrs. Ruth Y. Kennedy, 14 Fayette Pl. Greenbelt, Maryland 20770							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 2500 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes mellitus</u> (c) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 5</u> , 19 <u>80</u> , to <u>Sept. 23</u> , 19 <u>80</u> , that (I) <u>last</u> saw the deceased alive on <u>7/29</u> , 19 <u>80</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>viewed</u> (I) <u>did not</u> view the body after death.							
22b. SIGNATURE <u>E. Bieber</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-23-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD BIEBER, M.D.				22e. ADDRESS Box 246, Keedysville, Md., 21756			
23a. BURIAL, CREMATION, REMOVAL, DATE (SPECIFY) Burial Sept. 27, 1980		23b. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23c. LOCATION CITY OR TOWN COUNTY STATE Frederick Frederick Md.			
24. SIGNED BY REGISTRAR S. R. Fudeley, Keedysville, Md. 21756				25. REGISTERED BY REGISTRAR SEP 26 1980			
26. SIGNED BY REGISTRAR 106 E. Church St., Fred. Md. 21756				27. REGISTRAR'S SIGNATURE <u>notary McCreedy</u>			

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M 7/77

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 24284		
1. DECEASED NAME (TYPE OR PRINT) Calvin Reed Carter						2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Sept 12, 80		2c. MONTH DAY YEAR 12 19 80		2d. HOUR MIN 12:30 P M		
3. SEX male		4. RACE cauc.		5. DATE OF BIRTH MONTH DAY YEAR Feb. 5, 1935		6. AGE (IN YEARS) (LAST BIRTHDAY) 45 YRS		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.			
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cable Tech.		12b. KIND OF BUSINESS OR INDUSTRY Phone Co.	
13a. STATE W. Va.			13b. COUNTY Jefferson		13c. CITY OR TOWN Shepherdstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route # 45 - P. O. Box 433			
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Calvin Carter						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Pearl Thompson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. Korean Conflict 232-62-7500			17. INFORMANT ADDRESS Linda L. Carter Shepherdstown, WV 25443						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage N 853 DUE TO, OR AS A CONSEQUENCE OF (b) Skull fracture DUE TO, OR AS A CONSEQUENCE OF (c) Motor vehicle collision E 812 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH 3:45 P.M. Sept 10, 80				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:45 P.M. Sept 10, 80				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) truck auto collision				
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>				21e. LOCATION OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) highway				21f. LOCATION STREET CITY OR TOWN COUNTY STATE U.S. Rt 11 Falling Waters W.Va				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE Harold R. Tritch Jr.				TITLE (SPECIFY) deputy				DATE SIGNED Sept. 12, 80				
EXAMINER'S NAME (TYPE OR PRINT) Harold Tritch Jr. M.D.				ADDRESS 138 E. Antietam St Hagerstown M.d.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/15/80		23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Shepherdstown, W. Va.				
24. FUNERAL DIRECTOR NAME ADDRESS Robert L. Spencer P. O. Box 446						25a. DATE REC'D. BY REGISTRAR SEP 17 1980		25b. REGISTRAR'S SIGNATURE [Signature]				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 2 4 2 8 5	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH						REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) Dorothy Mae Clark				2a DATE OF DEATH MONTH DAY YEAR 9 12 80				2b HOUR 12:55 P M			
3 SEX F		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov 8 1934		6 AGE (IN YEARS LAST BIRTHDAY) 45 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		7b IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD					
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE Maryland				13b CITY OR TOWN Williamsport		13c INSIDE CITY LIMITS? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d STREET ADDRESS 3 Van Lear Drive			
14. FATHER'S NAME FIRST MIDDLE LAST Norris C. Wilson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phyllis M. Wolfkill							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17 INFORMANT ADDRESS Richard Clark, 3 Van Lear Drive							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adeno carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>with brain metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 months</u> <u>1 month</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (1) (this hospital) attended the deceased from <u>May 25</u> , 19 <u>79</u> , to <u>Sept 12</u> , 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>Sept 12</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Richard E. Smith, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED <u>9/12/80</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Smith, M.D.				22e ADDRESS 1708 Oak Hill Ave. Hagerstown, Md.							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 9-16-80		23c NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Md.					
24 FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hag., Md.				25a DATE SEP 18 1980		25b BY REGISTRAR		25c REGISTRAR'S SIGNATURE <u>John J. McBrady</u>			



Hand Haven Funeral Chapel, Inc., Hag., Md. 26918 1980

2-1-80 Hand Haven Cemetery, Hand, Md.

Hand Haven Cemetery, Hand, Md.

Hand Haven Cemetery, Hand, Md.

Hand Haven Cemetery, Hand, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 4 2 8 6			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
Margaret Elizabeth Clipp				Sept. 17, 1980			
3. SEX				2b. HOUR			
Female				10:30aM			
4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
White		MONTH DAY YEAR		73		IF UNDER 24 HRS	
		Sept. 9, 1923		YRS.		MONTHS DAYS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.		Washington County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		218 Division Avenue		Resturant Manager		Motel	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Maryland Baltimore Baltimore				13d. STREET ADDRESS			
				121 C Versailles Circle			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
Jacob R. Palmer				Nora Mae Gouker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT	
No				---		Route # 9 Box 69	
				217-12-1389		Judith A. Hamilton	
						Hagerstown, Md. 21740	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Heart Failure</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the Bowel</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 Months</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
None		-		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		P.M. None 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
		None					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 19 80</u> to <u>Sept. 17 19 80</u> , that (I) (we) lost saw the deceased alive on <u>Sept. 16 19 80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
<u>W. W. Lesh</u>				MD		9-19-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
William W. Lesh M.D.				411 Division Ave Hagerstown, Md. 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		9-19-80		Rest Haven Cemetery		Hagerstown, Md.	
24. FUNERAL DIRECTOR NAME				25a. RECEIVED BY NAME			
A.K. Coffman Funeral Home, Inc., Hagerstown, Md.				SEP 24 1980			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 4 2 8 7	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) David Glenn Collison			2. DATE OF DEATH Sept. 6, 1980		2b. HOUR M
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Jan. 5, 1971		6. AGE (IN YEARS LAST BIRTHDAY) 9 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Sharpsburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Rt. 2 Box 121
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Shirley Irene Collison		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-78-4568		17. INFORMANT ADDRESS Shirley I. Collison Rt. 2 Box 121 Sharpsburg	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> 7597 DUE TO, OR AS A CONSEQUENCE OF (b) <u>aspiration</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (c) <u>multiple congenital anomalies</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 min 30 min 8 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/6</u> 19 <u>80</u> , to <u>9/6</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9/6</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>William Joseph</u>				22c. DATE SIGNED 9-7-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Joseph				22e. ADDRESS WASH. CT. HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 9, 1980		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	
23d. LOCATION CITY OR TOWN Sharpsburg		23e. COUNTY Washington		23f. STATE MD	
24. FUNERAL DIRECTOR Osborne Funeral Home P.O. Box 983 Wmspt., MD				25a. DATE REC'D. BY REGISTRAR SEP 15 1980	
				25b. REGISTRAR'S SIGNATURE <u>Lincoln McCready</u>	



SEP 12 1932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 4 2 8 8	
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR
May Susan CRAMER			September 7, 1980		11:00am
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR
Female	White	Jan. 16, 1896	84 YRS.		MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Ohio	U.S.A.			Washington MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown	11 West Baltimore Street		housewife		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS	
Maryland		Washington	Hagerstown	11 West Baltimore Street	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
George		Eleanor		Smith	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS	
no		820-04-7734		Mr. Harry P. Cramer, Hagerstown, Maryland	
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes
410 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (b)					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from April 27, 1979, to July 29, 1980, that (I) saw the deceased alive on July 29, 1980, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) did not view the body after death.		22b. SIGNATURE DEGREE		22c. DATE SIGNED	
Robert Brull, M. D.		1198 Kenly Avenue Hagerstown, MD 21740		9/9/80	
23a. BURIAL, CREMATION, REMOVAL (IF OTHER, SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		Sept. 8, 1980	Smithsburg Crematorium	Smithsburg, Wash., Maryland	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
MINNICH FUNERAL HOME 415 East Wilson Blvd. Hagerstown, Maryland 21740		SEP 15 1980		L. J. McCreedy	

(M)

Ant. Brink

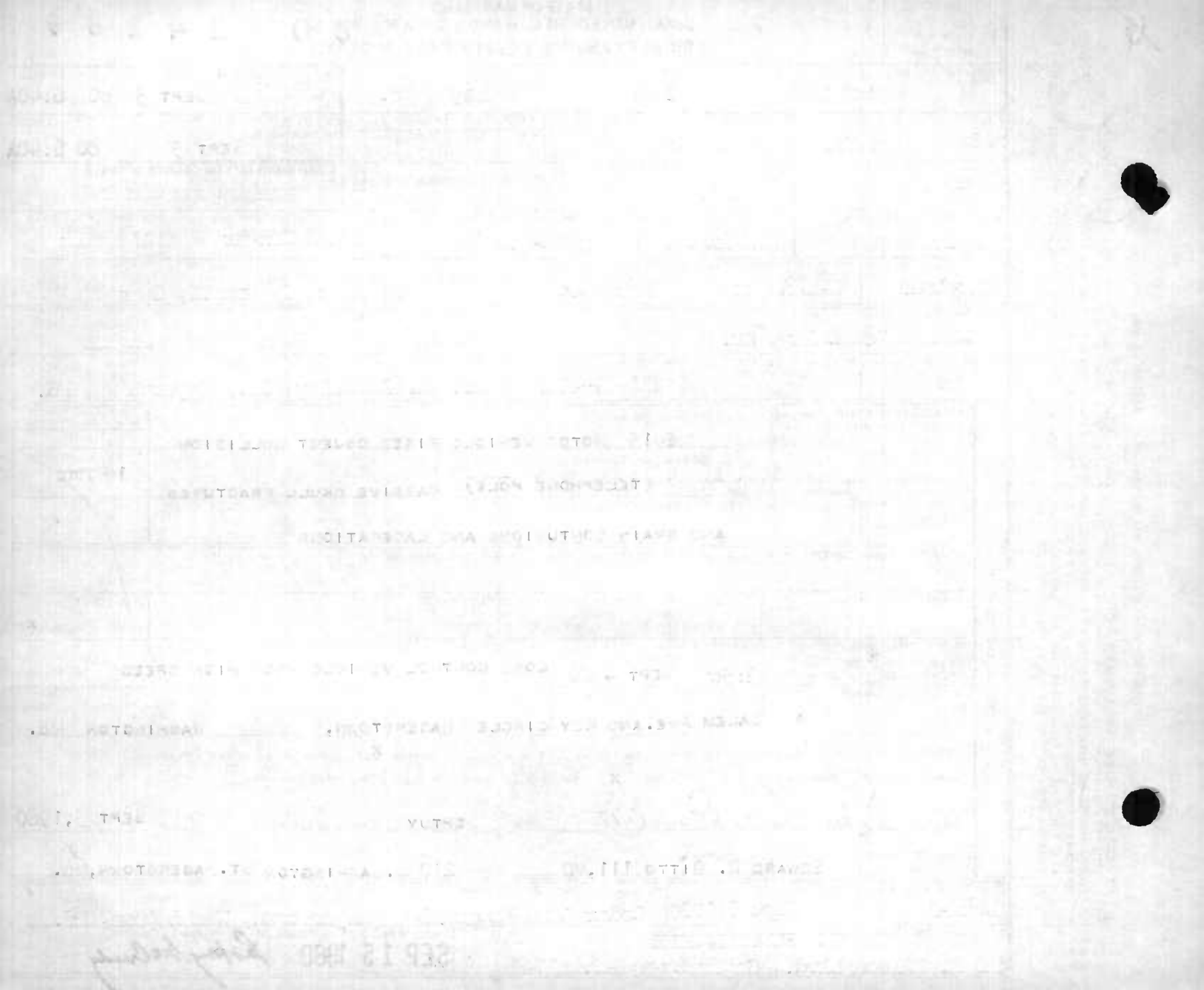
BP

DHMH - 17
(VR A15 ME (5))
15M7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 24289				
1. DECEASED NAME (TYPE OR PRINT) Donald Lee Daley, Jr.					2a. DATE KNOWN OF ESTI-MATED DEATH <input checked="" type="checkbox"/> SEPT 5, 1980					2b. HOUR 6:40A														
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 19, 1957		6. AGE (IN YEARS LAST BIRTHDAY) 23 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD SEPT 5, 1980		2d. HOUR 6:40A										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.									
10. CITY OR TOWN OF DEATH Hagerstown					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital					12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Truck Driver					12b. KIND OF BUSINESS OR INDUSTRY Elevator									
13a. STATE Maryland					13b. COUNTY Washington					13c. CITY OR TOWN Hagerstown					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET ADDRESS Route 6, Box 72, Cearfoss				
14. FATHER'S NAME FIRST MIDDLE LAST Donald Lee Daley, Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Jean Sigler					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 213-67-6783					17. INFORMANT ADDRESS Mr. Donald Daley, Sr., Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) E815 MOTOR VEHICLE FIXED OBJECT COLLISION DUE TO, OR AS A CONSEQUENCE OF (b) (TELEPHONE POLE) MASSIVE SKULL FRACTURES DUE TO, OR AS A CONSEQUENCE OF (c) AND BRAIN CONTUSIONS AND LACERATIONS															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 HRS									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:58 P.M. SEPT 4, 80					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) LOSS CONTROL VEHICLE FROM HIGH SPEED														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) SALEM AVE. AND KEY CIRCLE HAGERSTOWN,					21f. LOCATION STREET CITY OR TOWN COUNTY STATE WASHINGTON MD.														
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																								
ACTUAL SIGNATURE <i>Edward W. Ditto</i>					TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER					DATE SIGNED SEPT 5, 1980														
EXAMINER'S NAME (TYPE OR PRINT) EDWARD W. DITTO 111, MD					ADDRESS 217 W. WASHINGTON ST. HAGERSTOWN, MD.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial					23b. DATE Sept 8, 1980					23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Memorial					23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Md.									
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME										25a. DATE REC'D. BY REGISTRAR SEP 15 1980					25b. REGISTRAR'S SIGNATURE <i>Anthony A. Cruddy</i>									
415 E. Wilson Blvd., Hagerstown, Md. 21740																								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 4 2 9 0
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Katherine Ross Davies		2a. DATE OF DEATH MONTH DAY YEAR 9 16 80	
3. SEX Female		2b. HOUR 11 PM	
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 27, 1900	
6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Clerk		12b. KIND OF BUSINESS OR INDUSTRY School System	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE W.Va.		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13c. CITY OR TOWN Berkeley		13d. STREET ADDRESS 505 S. Queen St.	
14. FATHER'S NAME FIRST MIDDLE LAST Walter S Ross		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Unk Newton	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 027-20-2072	
17. INFORMANT ADDRESS Rt # 2, Box 185 Bunker Hill, WV			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410 - Acute myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 HRS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9-16, 19 80, to 9-16, 19 80, that (I) (we) last saw the deceased alive on 9-16, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Louis W. Kogelschatz MD		22c. DATE SIGNED 9-17-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis W. Kogelschatz		22e. ADDRESS 815 W. King St Martinsburg, WV	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/18/1980	
23c. NAME OF CEMETERY OR CREMATORY Omps Cremation Ser.		23d. LOCATION CITY OR TOWN COUNTY STATE Winchester Frederick, Va.	
24. FUNERAL DIRECTOR Louis W. Kogelschatz		25. DATE REC'D BY REGISTRY SEP 23 1980	



080 3 932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 4 2 9 1			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) DEAL, ETHEL M.				2a. DATE OF DEATH MONTH DAY YEAR 9/25/80		2b. HOUR 8:AM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 25, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. CITY OR TOWN Smithsburg		13c. STREET ADDRESS Rt. 3	
14. FATHER'S NAME FIRST MIDDLE LAST Hiram W. Kipe				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine J. Wetzel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-14-6330D		17. INFORMANT ADDRESS Mrs. Ruby Dorr 8516 Potomac Ave. College Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4370 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Due to, or as a consequence of Chronic Respiratory failure 24hr (b) Genetic Cerebral ASD Due to, or as a consequence of ASD. Cerebral vascular insufficiency of 10 years (c) ASD. Cerebral vascular insufficiency of 10 years PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11/15/73 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/25/80 to 9/25/80 , that (I) (we) lost the deceased alive on 9/25/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Mokhtar Milaninia				DEGREE		22c. DATE SIGNED 9/25/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mokhtar Milaninia, M.D.				22e. ADDRESS Western Maryland Hospital Center 1500 Pennsylvania Ave., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/28/1980		23c. NAME OF CEMETERY OR CREMATORY Ringgold Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Ringgold Washington Md.	
24. FUNERAL DIRECTOR NAME David V. Gove				ADDRESS 50 S. Broad St. Waynesboro, Pa.		25a. DATE REC'D. BY REGISTRAR SEP 29 1980 25b. REGISTRAR'S SIGNATURE notary/real	



1110 Lawrence Ave.
College Park, Md.

211-31-5230 Mrs. Mary Port

Catherine

Rita

Henry

x

Quawila

Leaf

Leaf

Leaf

Leaf

211-31-5230 Mrs. Mary Port

211-31-5230 Mrs. Mary Port

211-31-5230 Mrs. Mary Port

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE **8 0 2 4 2 9 2**
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Catherine Jane DeLaughter</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>September 15, 1980</i>	
3 SEX <i>Female</i>	4 RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Aug. 17, 1912</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>68</i> YRS	7c. HOUR <i>M</i>
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington County, Md.</i>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STREET ADDRESS <i>329 S. Cannon Avenue</i>		13b. INSIDE CITY LIMITS? <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Jacobs</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Pearl Carbaugh Jacobs</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-24-8950</i>	
17. INFORMANT ADDRESS <i>Richard H. DeLaughter, 329 S. Cannon</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute Leukemia</i> 2080 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? <i>YES</i> <input type="checkbox"/> <i>NO</i> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <i>YES</i> <input type="checkbox"/> <i>NO</i> <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <i>Jan 1980</i> to <i>Sept 15, 1980</i> , that (1) (we) lost saw the deceased alive on <i>Sept 14, 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did/did not) view the body after death.			
22b. SIGNATURE <i>L W</i>		22c. DATE SIGNED <i>9/15/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>L WALDRON MD</i>		22e. ADDRESS <i>138 E Antietam St.</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9-17-80</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash., Md.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Rest Haven Funeral Chapel, Inc., Hag., Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 18 1980</i>	
		25b. REGISTRAR'S SIGNATURE <i>Henry McBrady</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 2 4 2 9 3	
1- FOR STATE REGISTRAR										CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)										REG. NO.	
2a. DATE OF DEATH										2b. HOUR	
3 SEX										4 RACE	
5 DATE OF BIRTH										6 AGE (IN YEARS LAST BIRTHDAY)	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 BALTIMORE CITY OR COUNTY OF DEATH	
10 CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE										13b. COUNTY	
13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?	
13e. STREET ADDRESS										13f. STREET ADDRESS	
14 FATHER'S NAME										15. MOTHER'S MAIDEN NAME	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b. SOCIAL SECURITY NO.	
17 INFORMANT										ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line, (a) or (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. TIME OF INJURY	
21a. INJURY OCCURRED										21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										21d. LOCATION	
22a. I certify that (I) (this hospital) attended the deceased from										22b. DATE SIGNED	
22c. SIGNATURE										22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL										23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION	
24 FUNERAL DIRECTOR										24b. ADDRESS	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 4 2 9 4	
1. FOR STATE REGISTRAR			REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) Emma Marie DOUB			2a. DATE OF DEATH MONTH DAY YEAR September 27, 1980		2b. HOUR 9:55 AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Jan. 2, 1888	6 AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ravenwood Lutheran Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Maryland			13a. COUNTY Washington	13b. CITY OR TOWN Funkstown	13c. STREET ADDRESS 6 East Baltimore Street
14 FATHER'S NAME FIRST MIDDLE LAST Newton J. Warrenfeltz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Stockslager		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-74-1622	17 INFORMANT ADDRESS Anna S. Warrenfeltz, Funkstown, Maryland		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Myocardial Infarction</u> (c) <u>Coronary Artery Disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/26/80</u> , to <u>Sept 27, 1980</u> , that (I) (we) last saw the deceased alive on <u>9/26/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Edmund Konstein</u> M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/27/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>EDMUND KONSTEIN</u>			22e. ADDRESS <u>1010 N. KENSTEN FUNKSTOWN MD</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 30, 1980	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION Hagerstown, Wash., Maryland
24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740			25a. DATE REC'D. BY REGISTRAR OCT 1 1980		25b. REGISTRAR'S SIGNATURE <u>Turkey McBrady</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 80 24295		
1. FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		
			FIRST MIDDLE LAST Blaine Hafer Duey		MONTH DAY YEAR September 5, 1980		
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 16, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Comptroller		12b. KIND OF BUSINESS OR INDUSTRY Pangborne	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Williamsport		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Duey		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Emma Hafer		13e. STREET ADDRESS Milestone Garden Apartments			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 214-09-6148		17 INFORMANT ADDRESS Elizabeth Duey Milestone Garden Apartments			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Cerebrovascular Accident</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>NOV 9-5 1980</u> to <u>9-5 1980</u> , that (I) (we) last saw the deceased alive on <u>9-5 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>James A. ...</u>				DEGREE MD		22c. DATE SIGNED 9-8-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 7, 1980		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Shippensburg PA	
24 FUNERAL DIRECTOR NAME Osborne Funeral Home				25a. DATE REC'D. BY REGISTRAR SEP 15 1980			
ADDRESS P.O. Box 348 Wmspt., MD				25b. REGISTRAR'S SIGNATURE <u>Robert M. ...</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 4 2 9 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MARY WATSON FOREMAN				2a. DATE OF DEATH MONTH DAY YEAR Sept 6, 1980		2b. HOUR 4:45 A M	
3. SEX F		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Feb 10 1903		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) knitter		12b. KIND OF BUSINESS OR INDUSTRY stocking mill	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12 S. Walnut St.	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN C. Shifert				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth - BERRY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219 05 2627		17. INFORMANT ADDRESS Mary Jane Hannon 1528 Dual Highway Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized peritonitis 1533 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Sigmoid colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) 6 mos.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Liver metastases							
19a. DATE OF OPERATION Aug 7, 1980		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Sigmoid colon		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Aug 1, 1980 to Sept 6, 1980 , that (I) (we) lost saw the deceased alive on Sept 6, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John C. Moran				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/6/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (CHECK) Burial		23b. DATE 9-9-80		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Greencastle Penna.	
24. FUNERAL DIRECTOR NAME Gerald N. Minnich				25a. DATE REC'D. BY REGISTRAR SEP 11 1980		25b. REGISTRAR'S SIGNATURE Dorothy McBrady	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 4 2 9 7			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Rayetta Marie GAY			2a DATE OF DEATH MONTH DAY YEAR 9/23/80			2b HOUR 7:00p.m.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 6/28/52		6 AGE (IN YEARS LAST BIRTHDAY) 28 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Hospital Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook & Dish wash		12b KIND OF BUSINESS OR INDUSTRY College	
13a STATE Maryland		13b COUNTY Washington		13c CITY OR TOWN Harpers Ferry		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST William Leroy GAY		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flossie Evelyn MYERS		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b SOCIAL SECURITY NO. 236-80-5428		17 INFORMANT ADDRESS Route 1, Box 237					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days (b) Pulmonary infarction, LLL 3 days (c) Status post meningococcal meningitis 7 months							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept 17 19 80 to Sept. 23 19 80 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Sept. 23 19 80 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)							
22b SIGNATURE Fe U. Porciuncula				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 9/24/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Fe U. Porciuncula, M.D.				22e ADDRESS 1500 Pennsylvania Ave., Hagerstown, MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 9/27/80		23c NAME OF CEMETERY OR CREMATORY Samples Manor Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Samples Manor, Maryland	
24 FUNERAL DIRECTOR NAME Robert L. Spencer				ADDRESS Harpers Ferry, W V		25a DATE REC'D. BY REGISTRAR SEP 30 1980	
				25b REGISTRAR'S SIGNATURE <i>[Signature]</i>			

NAME	DATE	LOCATION	TIME
Robert L. Spencer	9/27/80	Samuel's Manor, Maryland	1:00p.
William I. Gay - Father Harpers Ferry, W V	9/28/80	Route 1, Box 237	
William I. Gay - Father Harpers Ferry, W V	9/28/80	Route 1, Box 237	
Washington Harpers Ferry	9/28/80	Route 1, Box 237	
Western Maryland Hospital Center	9/28/80	Route 1, Box 237	
Washington County	9/28/80	Route 1, Box 237	

NAME	DATE	LOCATION	TIME
Robert L. Spencer	9/27/80	Samuel's Manor, Maryland	1:00p.
William I. Gay - Father Harpers Ferry, W V	9/28/80	Route 1, Box 237	
William I. Gay - Father Harpers Ferry, W V	9/28/80	Route 1, Box 237	
Washington Harpers Ferry	9/28/80	Route 1, Box 237	
Western Maryland Hospital Center	9/28/80	Route 1, Box 237	
Washington County	9/28/80	Route 1, Box 237	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 4 2 9 8	
1. FOR STATE REGISTRAR			REG. NO.								
1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
JOHN					GERA	9 22 80					4 45 P M
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
male		white		August 12, 1891		89 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Hungary		U.S.A.				Washington MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Washington County Hospital				Self Employed		Real Estate machinist			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. COUNTY		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS		
Maryland			Howard		Ellicott City		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3629 Chatham Rd.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
John			Gera Sr.			Anna V. Yoo					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
no			216-12-7843			Irene Seivold			item # 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>HYPERKALEMIC, HYPERCHLOREMIC ACIDOSIS</u>										16 hr	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u>										24 hr	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>INFECTED GASTROSTOMY SITE</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
8/14/80		RUPTURED AORTIC ANEURYSM		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>8/14, 19 80</u> , to <u>9/22, 19 80</u> , that (I) (we) lost saw the deceased alive on <u>9/22, 19 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
John R. Marsh, M.D.				9/22/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
JOHN R. MARSH, M.D.		239 N. POTOMAC ST. HAGERSTOWN, MD. 21740									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Cremation		Sept. 23, 1980		Smithsburg Crematory		Smithsburg		Washington		MD	
24 FUNERAL DIRECTOR NAME		ADDRESS		25. DATE REC'D. BY REGISTRAR		26. REGISTRAR'S SIGNATURE					
Osborne Funeral Home		P.O. Box 348 Wmspt., MD		OCT 3 1980							

BP

0937 8700

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

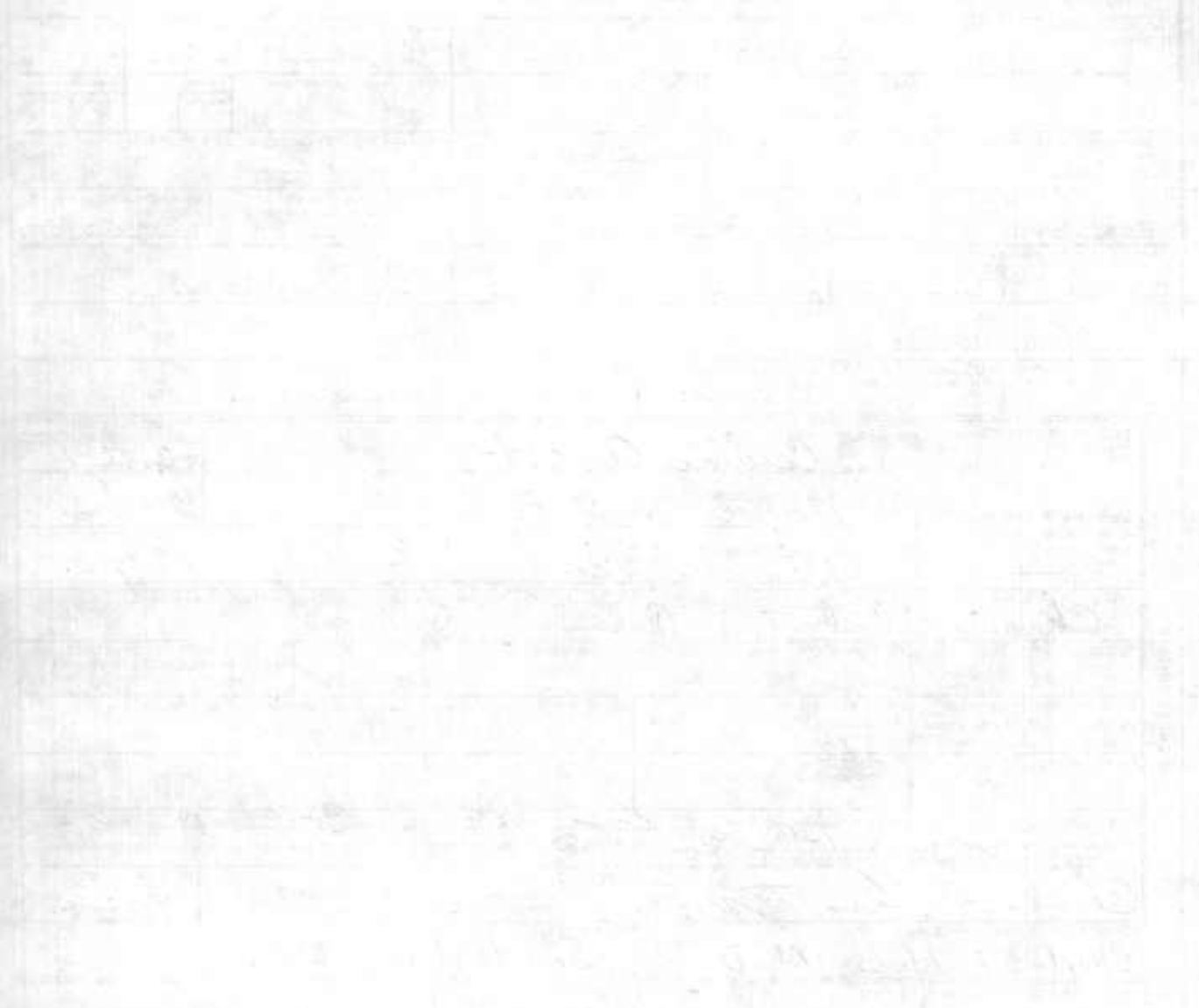
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M
(VRA 15, 41/179)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 0 2 4 2 9 9		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) John Carlton GORMAN				2a. DATE OF DEATH MONTH DAY YEAR September 10, 1980				2b. HOUR M	
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 2, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) layout		12b. KIND OF BUSINESS OR INDUSTRY aircraft mfg.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 302 Greendale Dr.			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Gorman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lola Riley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-09-0448		17. INFORMANT ADDRESS Mary Gorman, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> 4292 } DUE TO, OR AS A CONSEQUENCE OF conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Cardiovascular Disease</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Inst.</i> <i>24 hrs.</i> <i>10 yrs.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Chronic Obstructive Pulmonary Disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>8-12-80</i> to <i>9-10-80</i> , that (we) last saw the deceased alive on <i>9-10-80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.									
22b. SIGNATURE <i>Charles F. Hess M.D.</i>				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-12-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. Hess M.D.				22e. ADDRESS Smithsburg Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Sept. 13, 1980		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Md.			
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME				24b. ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740		24c. DATE OF DEATH SEP 13 1980			

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.



1913

#5 per Call w/F.H. 9/24/80 km

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0

2 4 3 0 0

1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SHIRLEY N GRAHAM			2a. DATE OF DEATH MONTH DAY YEAR Sept. 11, 1980			2b. HOUR 4:40 AM	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Sept. 11, 1913	6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine	7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY House Work	
13a. STATE Penna	13b. COUNTY Franklin	13c. CITY OR TOWN Greencastle	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 265 N. Carlisle St		
14. FATHER'S NAME FIRST MIDDLE LAST John B. King		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unable to Obtain					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 006-K0-702-4		17. INFORMANT ADDRESS Mrs. Claire V. Pellegri, Greencastle, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas with metastasis 15499 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) obstructive jaundice							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Aug. 28 , 19 80 , to Sept. 11 , 19 80 , that (I) (we) last saw the deceased alive on Aug 10 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C. Su		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Sept. 11, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Su		22e. ADDRESS 239 N. Potomac St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/15/1980		23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Orono, Maine	
24. FUNERAL DIRECTOR NAME Harold M. Zimman		ADDRESS Greencastle, Pa.		25a. DATE REC'D. BY REGISTRAR SEP 15 1980		25b. REGISTRAR'S SIGNATURE Dorothy McCreedy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after burial with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM-16 25M
(VRA 15, 4) 1/79

FOR <i>those who are married</i> STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 4 3 0 1			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Emory Stansbury GROVE				September 23, 1980				M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. IF UNDER 1 YEAR		7b. IF UNDER 24 HRS	
male		white		March 4, 1895		85 YRS.		MONTHS DAYS		HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8b. CITIZEN OF WHAT COUNTRY?		8c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Washington MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Washington County Hospital				laborer		Brandt Cabinet Works			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS					
13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		927 Guilford Avenue			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Isaac D. Grove				Captolia Neal							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
Yes				W.W.I		Marie Barr, Salisbury, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>DIABETIS MELLITUS</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 6</u> 19 <u>80</u> to <u>Sept 23</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Sept 23</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>M.D.</u>				22c. DATE SIGNED <u>9/23/80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
12. AMARILLO M.D.				127 KING ST HAGERSTOWN MD 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
burial		Sept. 25, 1980		Rose Hill Cemetery		Hagerstown, Wash., Maryland					
24 FUNERAL DIRECTOR NAME				25a. DATE REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
MINNICH FUNERAL HOME				SEP 29 1980				<u>[Signature]</u>			
415 E. Wilson Blvd., Hagerstown, Md. 21740											

MEDICAL CERTIFICATION

1002



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 24302			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER GEORGE GROVE										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <input checked="" type="checkbox"/> SEPT. 23 19 80		2b. HOUR OF DEATH P M 11:35	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 4 28 01		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 79		IF UNDER 1 YR. MONTHS DAYS 79		IF UNDER 24 HRS. HOURS MIN. 79			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.			
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) shop worker		12b. KIND OF BUSINESS OR INDUSTRY railroad			
13a. STATE Penna.				13b. COUNTY Huntingdon		13c. CITY OR TOWN Orbisonia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS SR 1 Box 2			
14. FATHER'S NAME FIRST MIDDLE LAST Ira				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Ramsey									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 715-12-1110		17. INFORMANT ADDRESS Lottie Grove, SR 1 Box 2, Orbisonia, PA							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) #414 - ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF FOLLOWING (b) #E816 - MOTOR VEHICLE LOSS OF CONTROL AND RAN DUE TO, OR AS A CONSEQUENCE OF OFF ROAD (c) (LG. BILATERAL SUBDURAL HEMATOMA) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 - 24 HRS.													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):													
19a. DATE OF OPERATION 9/17/80				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? BILATERAL TREPHINE AND EVACUATION SUBDURAL HEMATOMA						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:00 xx Aug. 9 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) LOST CONTROL OF VEHICLE AND RAN OVER AN EMBANKMENT							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) RURAL ROUTE #994		21f. LOCATION APPROX. 1.2 MILE WEST OF STREET CITY OR TOWN COUNTY STATE THREE SPRINGS, HUNTINGDON, PENNA.							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <i>Edward W. Ditto, III</i>				TITLE (SPECIFY) M.D. DEPUTY				DATE SIGNED SEPT. 24, 1980					
EXAMINER'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.				ADDRESS HAGERSTOWN, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9-26-80		23c. NAME OF CEMETERY OR CREMATORY Haven Rest Mem. Park			23d. LOCATION CITY OR TOWN COUNTY STATE Shirleysburg Hunt. PA				
24. FUNERAL DIRECTOR NAME Maech R. Brown				ADDRESS Orbisonia, PA 17243		25a. DATE REC'D. BY REGISTRAR OCT 6 1980		25b. REGISTRAR'S SIGNATURE <i>Lifroy McCreedy</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 4 3 0 3			
FOR 1- STATE REGISTRAR				CERTIFICATE OF DEATH			
I. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
Norl Albert Harrison				Sept. 1 1980			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
Male		Black		Oct. 6 1904		75	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Va.		U.S.A.				Washington County MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Washington County Hospital		Laborer			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Md. Washington Hagerstown				13e. STREET ADDRESS			
				156 W. North Ave.			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
Isadore NMN Harrison				Sally NMN Mack			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.			
No				255-01-4740			
17 INFORMANT				ADDRESS			
Virginia Harrison				156 W. North Ave.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>							hours
2391 DUE TO, OR AS A CONSEQUENCE OF							months
(b) <u>Neoplasm (Tumor) of lung</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>chronic pulmonary disease + arteriosclerotic heart disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>80</u> , to <u>July 31</u> 19 <u>80</u> , that (II) (we) lost saw the deceased alive on <u>Aug. 31</u> 19 <u>80</u> , and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>WS Hood</u>		<u>MD</u>				<u>9-2-80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
<u>W S Hood</u>				<u>645 E. 1st St., Hagerstown Md</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
<u>Burial</u>		<u>9/5/80</u>		<u>Newtown Cem.</u>		<u>Harrisonb'g Rock Ham Va.</u>	
24 FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REGD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
<u>Dennis L. Davis</u>				<u>Smithburg, Md.</u>		<u>SEP 8 1980</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 4 3 0 4			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Joseph Glenn Hellane Jr.				2a. DATE OF DEATH MONTH DAY YEAR 9/14/80		2b. HOUR 1:55 AM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 12 13 1919		6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) data processor		12b. KIND OF BUSINESS OR INDUSTRY railroad	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b CITY OR TOWN Washington 13c CITY OR TOWN Hagerstown				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2 Englewood Road	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph G. Hellane, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth H. Maugans			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II		17 INFORMANT ADDRESS Frances L. Hellane, Hagerstown, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Probable Mesenteric Infarction 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma of colon. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hours 3 years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (his hospital) attended the deceased from Nov 19 77 , to Sept 16 19 80 , that (1) (we) lost saw the deceased alive on Sept 15 19 80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did not view the body after death.							
22b. SIGNATURE Richard E. Smith, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/16/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Smith, M.D.				22e. ADDRESS 1708 Oak Hill Ave., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Sept. 18, 1980		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24 FUNERAL DIRECTOR MINNICH FUNERAL HOME NAME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR SEP 19 1980		25b. REGISTER SIGNATURE <i>[Signature]</i>	

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DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Theima G. Helser			2a. DATE OF DEATH MONTH DAY YEAR Sept. 13 1980		2b. HOUR 3:15 P.M.
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 18 1924		6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Penna.			13b. COUNTY Franklin	13c. CITY OR TOWN Waynesboro	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST James W. Morrow			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Baker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 201-16-0514		17. INFORMANT ADDRESS Box 61 R.D. 1 Mrs. Trudy Halterman Cascade, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INCREASED INTRACRANIAL PRESSURE</u> 4349 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MULTIPLE CEREBRAL INFARCTS</u> (c) <u>CEREBRAL ARTERIO SCLEROSIS</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward B. Byrd M.D.		DEGREE		22c. DATE SIGNED 15 Sept. 80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD B. BYRD, M.D.		22e. ADDRESS 1190 MT. AETNA RD. HAGERSTOWN MD.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/16/1980		23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Waynesboro Franklin Penna.		23e. DATE REC'D. BY REGISTRAR SEP 22 1980		23f. REGISTRAR'S SIGNATURE [Signature]	
24. FUNERAL DIRECTOR NAME David H. Gure		ADDRESS 50 S. Broad St. Waynesboro, Pa.		24. DATE REC'D. BY REGISTRAR SEP 22 1980	

BP



Washington Co. Supply Co.
1000 1st St. N.E.
Washington, D.C.
20002

Mr. J. Edgar Hoover
Federal Bureau of Investigation
Washington, D.C.

Dear Sir:

Enclosed for you are two copies of a letterhead memorandum dated and captioned as above.

Very truly yours,
[Signature]



SEP 23 1980
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 4 3 0 6

FOR
1 - STATE
REGISTRAR

REG. NO.

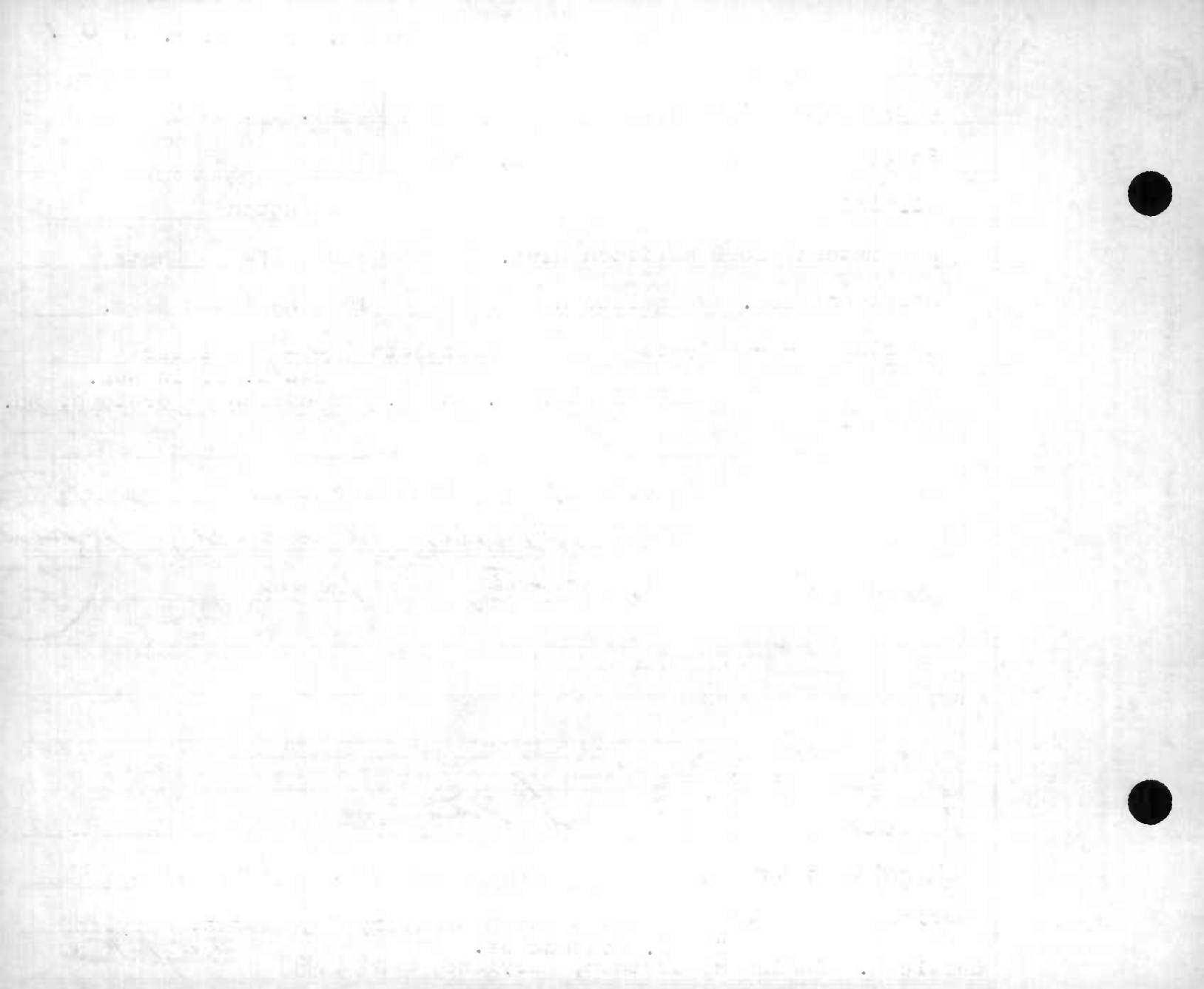
1. DECEASED NAME (TYPE OR PRINT) Raymond Marshall Hess			2a. DATE OF DEATH MONTH DAY YEAR Sept. 11, 1980			2b. HOUR M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6-27-01	6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD					
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) parts dept.		12b. KIND OF BUSINESS OR INDUSTRY Auto			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown			
14. FATHER'S NAME FIRST MIDDLE LAST Uranza M. Hess			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Myrtle Gonder					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 09 1750A		17. INFORMANT ADDRESS Dorothy L. Hess see # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Extensive abdominal atherosclerosis</i> 1534 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis of vessels</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)	
19a. DATE OF OPERATION 9/5/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Small bowel obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from 9/4, 19 80, to 9/11, 19 80, that (I) (we) last saw the deceased alive on 9/11, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE John R. Marshall M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/16/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-15-80		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Maryland		
24. FUNERAL DIRECTOR NAME Gerald N. Minnich		305 N. Potomac St. ADDRESS Hagerstown, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 17 1980		25b. REGISTRAR'S SIGNATURE P. J. McCreedy		

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 4 3 0 7
CERTIFICATE OF DEATH

FOR 1- STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Mary Anna Hildebrand		2a. DATE OF DEATH MONTH DAY YEAR Sept. 18, 1980	
3. SEX Female		2b. HOUR M	
4. RACE White		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
5. DATE OF BIRTH MONTH DAY YEAR May 1, 1904		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1008 Hamilton Blvd.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY home	
13a. STATE Maryland		13b. COUNTY Wash.	
13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1008 Hamilton Blvd.		14. FATHER'S NAME FIRST MIDDLE LAST Charles - - Myers	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth - - Zeigler		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	
16b. SOCIAL SECURITY NO. 219 52 2117		17. INFORMANT ADDRESS 248 E. Irvin Ave. Mrs. Ann E. Macpherson Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 4340 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardio-De. years CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.		APPROXIMATE INTERVAL BETWEEN CAUSE AND DEATH 1 day years years	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus; obesity; - Depression.			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) XXXXXX attended the deceased from 24 October 19 58 to date 19 August 1980, and that in (my) XX opinion death occurred on the date and hour and from the causes stated above, (1) XXXXXX (did not) view the body after death.			
22b. SIGNATURE Richard T. Binford M.D.		22c. DATE SIGNED 19 Sept. 80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard T. Binford, M.D.		22e. ADDRESS 1135 Potomac Ave., Hagerstown, Md. 21740	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 9-22-80	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery Hagerstown, Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Gerald N. Minnich Hagerstown, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 24 1980	
25b. REGISTRAR'S SIGNATURE R. J. McCreedy		25c. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 4 3 0 8			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST <u>Lester</u> MIDDLE <u>C.</u> LAST <u>Hockensmith</u>				MONTH DAY YEAR			
<u>LESTER</u> <u>Hockensmith</u>				Sept. 25 1980			
3. SEX				7b. HOUR			
Male				10:45P M			
4. RACE				6. AGE (IN YEARS LAST BIRTHDAY)			
White				87 YRS.			
5. DATE OF BIRTH				8. IF UNDER 1 YEAR			
MONTH DAY YEAR				MONTHS DAYS HOURS MIN			
March 3 1893							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				9. BALTIMORE CITY OR COUNTY OF DEATH			
Penna.				Washington Co. MD.			
7b. CITIZEN OF WHAT COUNTRY?				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
U.S.A.				Machine operator Refrig. Co.			
10. CITY OR TOWN OF DEATH				12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown				Refrigeration Co.			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				13a. STREET ADDRESS			
Washington Co. Hospital				110 Greenhill Drive			
13b. COUNTY				13c. CITY OR TOWN			
Washington				Hagerstown			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
Milton M. Hockensmith				Mary A. E. Seiss			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				17. INFORMANT			
No				Mrs. Miriam Finz			
16b. SOCIAL SECURITY NO				ADDRESS			
173-03-3739 A				110 Greenhill Drive Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST / HYPOTENSION</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>Septic SHOCK</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <u>rupture diverticuli / peritonitis</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
19c. DATE OF OPERATION				19d. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY			
				HOUR A.M. MONTH DAY YEAR			
				P.M. 19			
21c. INJURY OCCURRED				21d. PLACE OF INJURY			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21e. INJURY OCCURRED				21f. LOCATION			
				STREET CITY OR TOWN COUNTY STATE			
22a. certify that (I) (this hospital) attended the deceased from <u>9/25/80</u> to <u>9/25/80</u> , that (I) (we) lost saw the deceased alive on <u>9/25/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE							
DEGREE							
22c. DATE SIGNED							
9/26/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)							
22e. ADDRESS							
1825 Howell Rd HAGST. MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			
Burial				9/29/1980			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Blue Ridge Cemetery				Thurmont Frederick Md.			
24. FUNERAL DIRECTOR				25. ATTESTED BY REGISTRAR			
David Y. Grove				50 S. Broad St. Waynesboro, Pa.			

WASHINGTON, D.C. 20540
JAN 19 1960
U.S. DEPARTMENT OF THE ARMY
HEADQUARTERS, ARMY
WASHINGTON, D.C.

TO: THE SECRETARY OF THE ARMY
FROM: THE CHIEF OF STAFF
SUBJECT: [Illegible]
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 4 3 0 9			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Carl Franklin HUMBERTSON				September 13, 1980				M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		7 IF UNDER 24 HRS	
Male		White		Feb. 4, 1920		60		MONTHS		DAYS	
2b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Washington				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Washington County Hospital		Machinist		Pangboro					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		412 Michigan Avenue			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
William G. Humbertson				Eliza Grady							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		12 INFORMANT		ADDRESS			
yes				W.W. 11		220-10-9023		Mrs. Ruth M. Humbertson, Hagerstown, Md.			
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <i>1629 Dist cell carcinoma of lung w metastasis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastasis</i>								20 months			
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1-2</i> 19 <i>79</i> , to <i>9-13</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>9-13</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<i>Richard E. Smith, M.D.</i>										<i>9-15-80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Richard E. Smith, M. D.				1708 Oak Hill Ave., Hagerstown, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		STATE	
Burial				Sept. 16, 1980		Cedar Lawn Mem. Park		Hagerstown, Wash., Maryland			
24 FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS											
415 E. Wilson Blvd., Hagerstown, Maryland 21740				SEP 18 1980				<i>Richard E. Smith</i>			



0891 81932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 4 3 1 0			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth ELIZABETH HUTZEL				2a. DATE OF DEATH MONTH DAY YEAR SEPT - 2 - 1980		2b. HOUR 9⁰² PM	
3 SEX F	4 RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 3 3 09		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 71 YRS.		IF UNDER 1 YEAR IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.		
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON Co. Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN MD WASHINGTON Hagerstown				13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS 817 Corbett St.	
14. FATHER'S NAME FIRST MIDDLE LAST Irvin Harbaugh		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Smith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 216-22-9317		17. INFORMANT ADDRESS Mr. Ralph D. Hutzel, 817 Corbett St. Hagerstown, Md. 21740			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOGENIC Shock + Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 hours years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF INJURY, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Aug 31 19 80 , to Sept 2 19 80 , that (I) (we) last saw the deceased alive on Sept 2 19 80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W S Hood		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-2-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W S Hood		22e. ADDRESS 645 E 1st St. Hagerstown, Md 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-5-80		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Boonsboro, Wash. Co., Md.	
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.				ADDRESS Boonsboro, Md. 21713		25a. DATE REC'D. BY REGISTRAR SEP 5 1980	
						25b. REGISTRAR'S SIGNATURE [Signature]	

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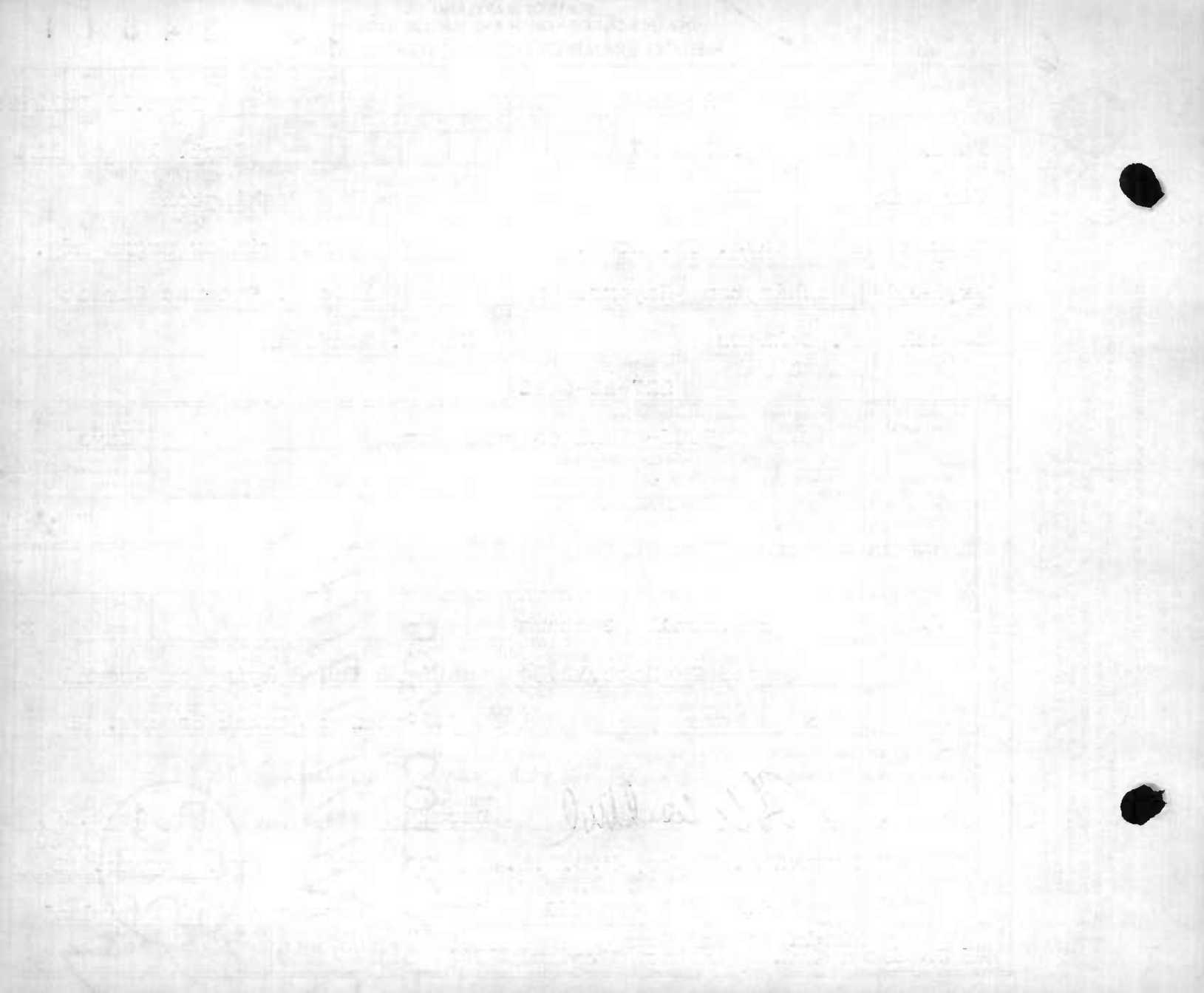
BP

DHMH - 17
(VR A15 ME (5))
15M/7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 24311	
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Pauline Virginia IRWIN										2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR Sept. 19, 1980	
3. SEX		4. RACE		5. DATE OF BIRTH (MONTH DAY YEAR)		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		2c. DATE PRONOUNCED DEAD	
Female		White		Aug. 17, 1897		83 YRS.				2d. HOUR 12:55 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Co. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) parts winder organ mfg.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1054 S. Potomac Street			
14. FATHER'S NAME FIRST MIDDLE LAST Samuel H. Cullers						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida B. Kauffman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. 227-22-0492		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) E885- Fall on same level DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION 9/12/80				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? subdural hematoma						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:30 PM Sept. 12, 80		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) patient found lying on ground by fence					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION CITY OR TOWN COUNTY STATE 1054 S. Potomac Street Hagers. MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Howard N. Weeks</i>				TITLE (SPECIFY) Deputy				DATE SIGNED Sept. 20, 1980			
EXAMINER'S NAME (TYPE OR PRINT) Howard N. Weeks, M.D.P.A.				ADDRESS 580 Northern Ave. Hagers. MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Sept. 23, 1980		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland			
24. FUNERAL DIRECTOR NAME Minnich Funeral Home						25a. DATE REC'D. BY REGISTRAR SEP 25 1980		25b. REGISTRAR'S SIGNATURE <i>History McHenry</i>			
415 E. Wilson Blvd. Hagerstown, Maryland 21740											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMM - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 4 3 1 2
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John Dewey William I Fert			2a. DATE OF DEATH MONTH DAY YEAR September 8, 1980			2b. HOUR 6:10 M	
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 10, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.	
10. CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Williamsport Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farm Laborer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. STATE Md.		13b. COUNTY Fred.		13c. CITY OR TOWN Middletown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST DANIEL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
16b. SOCIAL SECURITY NO. 215-26-1800		17. INFORMANT ADDRESS Millard Sines Middletown, Md.					

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic Shock</u> 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerosis</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
---	--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1-4</u> , 19 <u>79</u> , to <u>7-8</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>7-14</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John R. Melnick				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Melnick, M.D.				22e. ADDRESS 16220 Frederick Rd. Gaithersburg, MD 20760			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept. 10, 1980		23c. NAME OF CEMETERY OR CREMATORY Davis Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg Wash Md.	
24. FUNERAL DIRECTOR NAME Gladhill Co. Middletown, Md.		ADDRESS 21769		25a. DATE REC'D. BY REGISTRAR SEP 16 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

082 81972

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 4 3 1 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Patrick Lester INGRAM				2a. DATE OF DEATH September 10, 1980		2b. HOUR M	
3. SEX male		4. RACE white		5. DATE OF BIRTH June 20, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Coffman Home for the Aging		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) custodian		12b. KIND OF BUSINESS OR INDUSTRY bank	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland				13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Charles Ingram				15. MOTHER'S MAIDEN NAME Annie Welch			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-09-9121		17. INFORMANT ADDRESS Lucille Ingram, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>cerebral Arteriosclerosis + Dementia</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>was</u> (hospital) attended the deceased from <u>6-7-79</u> , 19 <u>79</u> , to <u>9-10</u> , 19 <u>80</u> , that (I) <u>first</u> lost saw the deceased alive on <u>AUG 30</u> , 19 <u>80</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death.							
22b. SIGNATURE <u>Clayton Hoffman</u>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9-10	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Clayton A. Hoffman</u>		22e. ADDRESS <u>1147 Oak Hill Ave Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Sept. 13, 1980		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Md.	
24. FUNERAL DIRECTOR NAME Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Md.				25a. DATE REC'D. BY REGISTRAR SEP 15 1980		25b. REGISTRAR'S SIGNATURE <u>Anthony McBrady</u>	

0 1 2 3 4 5 6 7 8 9

SEP 10 1900

SEP 10 1900



SEP 10 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 19 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Cherie Frances Itnyre</i>				2a DATE OF DEATH MONTH DAY YEAR <i>09 09 80</i>		2b HOUR <i>8:45 PM</i>			
3. SEX <i>F</i>		4 RACE <i>W</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>02 12 35</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>45</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.					
10 CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>crossing guard</i>		12b KIND OF BUSINESS OR INDUSTRY <i>traffic dept.</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <i>Maryland</i> 13b COUNTY <i>Washington</i> 13c CITY OR TOWN <i>Hagerstown</i>						13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <i>737 Security Road</i>			
14 FATHER'S NAME FIRST MIDDLE LAST <i>James L. Kline</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Jaum F. Prosper</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. <i>220-30-9781</i>		17 INFORMANT ADDRESS <i>Jonas W. Itnyre, Hagerstown, Md.</i>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of lung with</i> <i>1629</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>metastases</i> DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (1) (this hospital) attended the deceased from <i>July 28</i> , 19 <i>80</i> , to <i>Sept 9</i> , 19 <i>80</i> , that (1) (we) last saw the deceased alive on <i>Sept 8</i> , 19 <i>80</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>Richard E. Smith, M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>9/9/80</i>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Richard E. Smith, M.D.</i>				22e ADDRESS <i>1708 Oak Hill Ave, Hagerstown</i>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b DATE <i>Sept. 11, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Shanktown Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Big Pool, Wash. Maryland</i>					
24 FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i>				24b ADDRESS <i>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>				25a DATE REC'D BY REGISTRAR <i>SEP 15 1980</i>			

BP.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		Sept.		4, 1980		AM	
3 SEX			4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			White		Nov. 25, 1945		34 YRS.		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
Maryland			U.S.A.				Washington MD.							
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Sharpsburg			Rt. 1 Box 149											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland			Washington		Sharpsburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Rt. 1 Box 149					
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME											
Joseph			Ruby EX											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS									
no			218-74-3320		Elmer L. Jamison Rt. 1 Box 149 Sharpsburg 21782									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic granulocyte leukemia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
2051 DUE TO, OR AS A CONSEQUENCE OF (b) _____										27 years				
DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
			HOUR A.M. MONTH DAY YEAR											
			P.M. 19											
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION								
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>						CITY OR TOWN COUNTY STATE								
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>														
22a. I certify that (I) (this hospital) attended the deceased from <u>4-7-</u> 19 <u>77</u> to <u>9-9-</u> 19 <u>80</u> , that (I) was last saw the deceased alive on <u>9-4-</u> 19 <u>80</u> , and that in (my) best opinion death occurred on the date and hour and from the causes stated above. (I) did (did) not view the body after death.														
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
<u>Joseph Secomdar</u>									9-5-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
JOSEPH SECOMDARI			1800 N BORO Md 21713											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE			
Burial			Sept. 6, 1980		Mt. View Cemetery		Sharpsburg		Washington		MD			
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
NAME ADDRESS			SEP 10 1980			<u>Jeffery McCreedy</u>								
Osborne Funeral Home P.O. Box 348 Wmspt., MD														

BP



SEP 10 1980

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5. YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
IVR A15 ME (5)
15M 7/76

1- FOR STATE REGISTRAR		11-10-80		21c. Film #G549 al		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		7 0		2 4 3 1 6	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH								REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)						FIRST		MIDDLE		LAST	
Floyd Wade Jenkins											
2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
Sept. 26, 1980		26		19		80		2PM			
3. SEX		4. RACE		5. DATE OF BIRTH (MONTH DAY YEAR)		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN	
Male		White		June 9, 1955		25 YRS					
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Washington					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Wash. Co. Hosp. King St.		Carpenter		Carpentry					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Wicomico		Salisbury				302 S. Pineway			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		17. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Milton James Jenkins		Doris Mae Disharoon		No		214-66-7836		Mrs. Nancy L. Jenkins (wife)		same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Brain Contusion</u> <u>E818</u>										days	
8189 } DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				P.M. Sept. 17, 1980				(E818=Fall from moving fell from back of truck vehicle.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
				MCI				Md. Correctional Inst. Hagers. MD Wash.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE			
<i>Howard N. Weeks</i>				M.D. Deputy				Sept. 26, 1980			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Howard N. Weeks, M.D.P.A.				580 Northern Ave. Hagers. MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		23e. COUNTY	
Burial				10/1/80		Springhill Mem. Gardens		Salisbury		Wicomico, Maryland	
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HOLLOWAY FUNERAL HOME				Salisbury, Md.				OCT 1 1980		<i>Rickey McCreedy</i>	

MEDICAL CERTIFICATION



x



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 4 3 1 7			
FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Edgar Lewis Jones				2a. DATE OF DEATH MONTH DAY YEAR September 23, 1980		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 1, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Woodworker		12b. KIND OF BUSINESS OR INDUSTRY Furniture	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Washington Hagerstown				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 3, Box 317-A	
14. FATHER'S NAME FIRST MIDDLE LAST Oscar Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Troupe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-18-9093		17. INFORMANT ADDRESS Hazel I. Jones, Rt. 3, Box 317-A			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LARGE CELL CARCINOMA OF THE 1629 DUE TO, OR AS A CONSEQUENCE OF (b) LUNGS. DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OBSTRUCTIVE LUNG DISEASE PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MOS
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 17, 1967 to Sept 22, 1980 , that (I) (we) lost saw the deceased alive on Sept 22, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. Amarillo MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. AMARILLO MD				22e. ADDRESS 127 KING ST HAGERSTOWN MD 21740			
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE 9-26-80		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Wash., Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Rest Haven Funeral Chapel, Inc., Hag., Md.				25. DATE REC'D. BY REGISTRAR SEP 29 1980		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Howard Keats					2a. DATE OF DEATH MONTH September DAY 16 YEAR 1980 2b. HOUR 2 P. M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH January DAY 5 YEAR 1909		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.				
10. CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Homewood Retirement Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. KIND OF BUSINESS OR INDUSTRY Air Force		
13a. STATE Maryland					13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Unknown MIDDLE LAST 					15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE LAST 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 081-20-0854		17. INFORMANT ADDRESS Helen G. Keats, 221 Garlinger Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) Cancer } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 7 Prostate DUE TO, OR AS A CONSEQUENCE OF (c) 									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 22 , 19 80 , to Sept 16 , 19 80 , that (I) (we) lost saw the deceased alive on Sept 10 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Seamus Hester					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/18/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SIDNEY NOVERSTEIN					22e. ADDRESS FUNKS TOWN MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-18-80		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Md.		
24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hag., Md. ADDRESS 					25a. DATE REC'D. BY REGISTRAR SEP 22 1980			25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMM-16 20M
(VRA 15, 4) 7/78

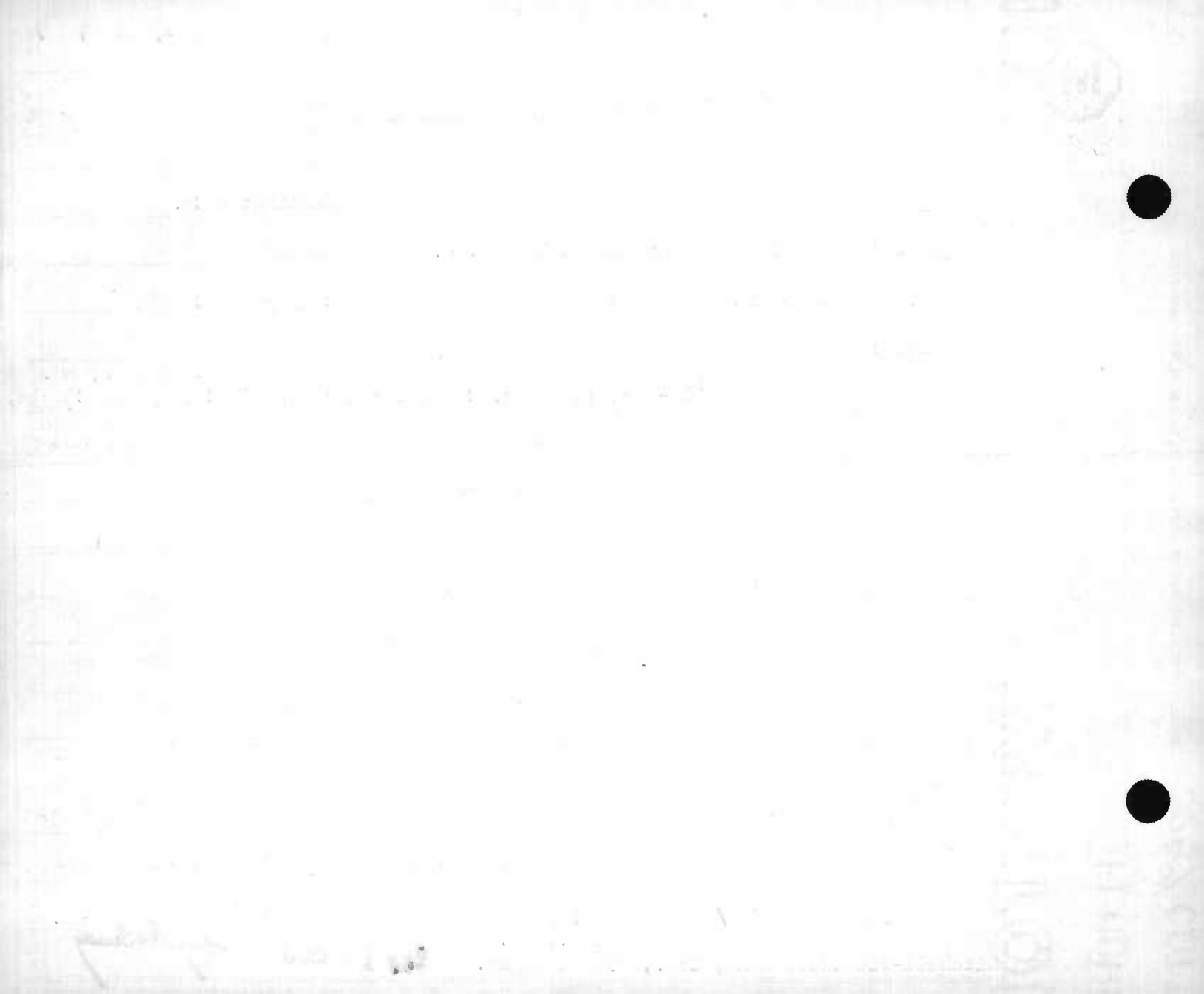
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 24319

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Mary A. Keavney</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Sept 10, 1980</i>			2b. HOUR <i>4:00 PM</i>						
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>9 30 1997</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>83</i>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Ireland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington Co.</i> MD.						
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Ravenwood Luther Village N. H.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <i>Md.</i>			13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>332 Cherrytree Circle</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Richard Bourke</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>215-24-1341D</i>		17. INFORMANT ADDRESS <i>Hagerstown, Md.</i>				17b. Mrs. Catherine Lorden, 332 Cherrytree Circle,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> <i>4140</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 + wks</i> <i>Years.</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Renal Insufficiency</i>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>14 Aug</i> 19 <i>78</i> , to <i>10 Sept</i> 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>10 Sept</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>W. N. Fender</i>			DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>11 Sept 1980</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. N. Fender</i>			22e. ADDRESS <i>138 E. Antietam St., Hagerstown Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>9/13/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Md.</i>					
24. FUNERAL DIRECTOR NAME <i>Mitchell-Wiedefeld Home, Inc.,</i>			ADDRESS <i>Balto., Md. 6500 York Rd.</i>			25a. DATE REC'D. BY REGISTRAR <i>SEP 17 1980</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 4 3 2 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Louise Keener				2a. DATE OF DEATH MONTH DAY YEAR September 9, 1980			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb. 8, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS	
7a. BIRTHPLACE (COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) sewerer		12b. KIND OF BUSINESS OR INDUSTRY dress mfg.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. CITY OR TOWN 13c. RESIDENCE BEFORE ADMISSION Maryland Washington Keedysville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Phillips				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flotie Arbogast			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 279-24-5239		17. INFORMANT ADDRESS Woodrow Keener, Keedysville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Alcoholic Cirrhosis</u> 5712 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/8</u> 19 <u>78</u> to <u>9/9</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9/8</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>R. Amarillo</u>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/10/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. AMARILLO		22e. ADDRESS 127 KING ST HAGERSTOWN MD 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Sept 11, 1980		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Md.				25a. DATE REC'D. BY REGISTRAR SEP 15 1980		25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>	

CLARKANA ST

SEP 12 1960

12

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

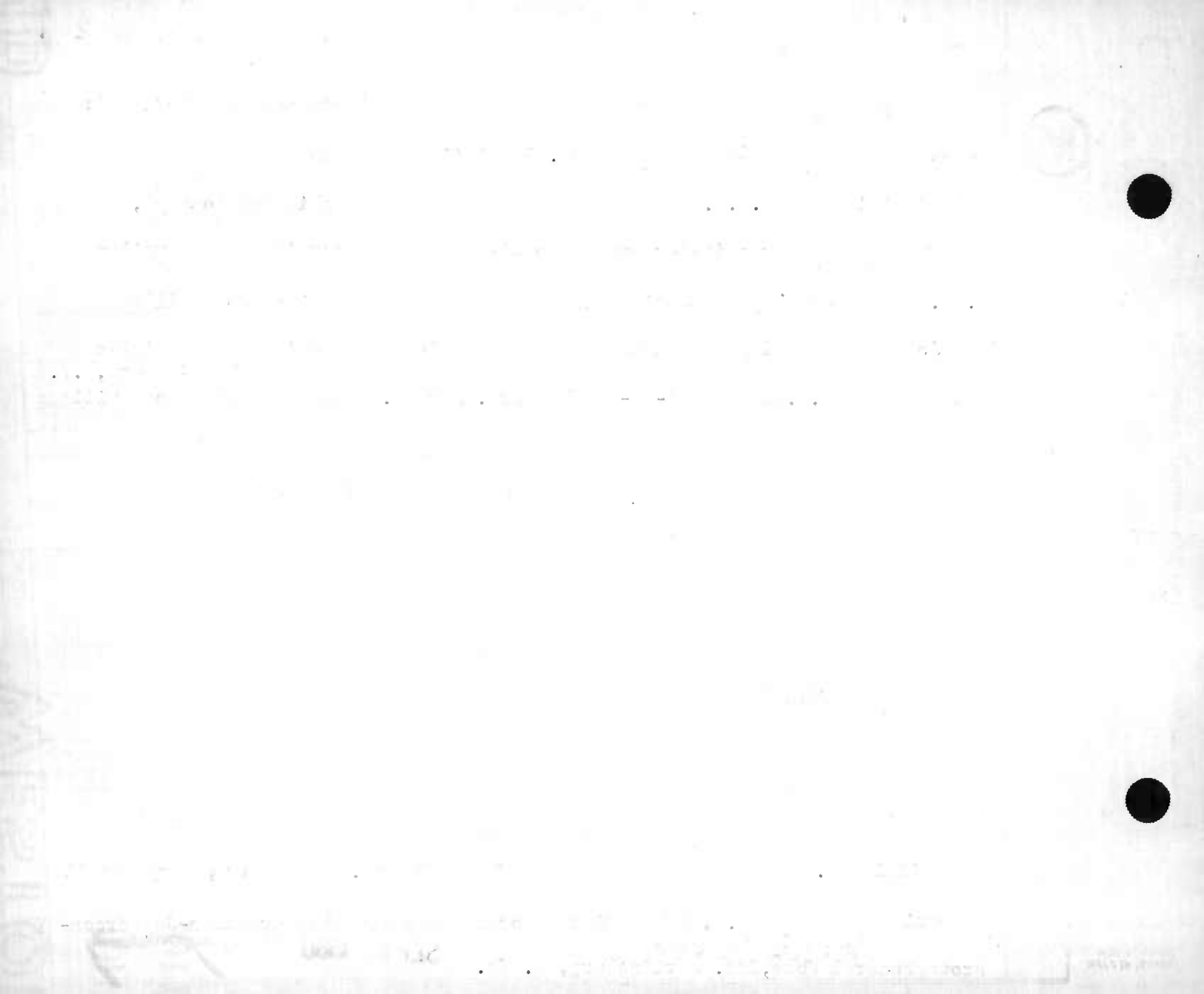
8 0 2 4 3 2 1

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROBERT CHESTER KEES			2a. DATE OF DEATH MONTH DAY YEAR September 1 1980			2b. HOUR 1:40A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 17 1919		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE W.Va.			13b. CITY OR TOWN Berkeley		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 202 Shenandoah Village		
14. FATHER'S NAME FIRST MIDDLE LAST John Wesley Kees			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Louise Miller						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II		17. INFORMANT ADDRESS Martinsburg, W.V. Mrs. Mary R. Kees 202 Shenandoah Village				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1889 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) anoxia coming from blood DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William G. Plavcan			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9-1-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William G. Plavcan					22e. ADDRESS 1198 Kenly Ave. Hagerstown, Maryland 21740				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 4, 1980		23c. NAME OF CEMETERY OR CREMATORY Christ Reformed Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Shepherdstown-Jefferson-WV		
24. FUNERAL DIRECTOR NAME Charles M. Brown					25. DATE REC'D. BY REGISTRAR SEP 8 1980				
Brown Funeral Home, Inc. Martinsburg, W. Va.									





STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 4 3 2 2

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Robert Alvin Kemp			2a. DATE OF DEATH MONTH DAY YEAR 09 26 80			2b. HOUR 4 ⁴⁵ A.M.				
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Oct. 19, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co., MD.				
10. CITY OR TOWN OF DEATH Hagers town		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co., Md.				12a. USUAL OCCUPATION (OF WORK FOR MOST OF WORKING LIFE) Paper Hanger		12b. KIND OF BUSINESS OR INDUSTRY Houses		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.			13b. CITY OR TOWN Wash. Hagerstown		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 505 W. Church St.			

14. FATHER'S NAME FIRST MIDDLE LAST Guy A. Kemp			15. MOTHER'S MAIDEN NAME FIRST MIDDLE Elsie M. Mills		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 203-10-7260		
17. INFORMANT ADDRESS Bernadine M. Bevard - Hagerstown, Md.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic CA</u> 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) ~~XXXXX~~ attended the deceased from April, 1971, to Sept 26, 1980, that (I) ~~(X)~~ lost saw the deceased alive on Sept. 25, 1980, and that in (my) ~~(X)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(X)~~ did not ~~move~~ the body after death.

27b. SIGNATURE <i>Howard N. Weeks</i>			27c. DATE SIGNED Sept. 26, 1980		
27d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard N. Weeks, M.D., P.A.			27e. ADDRESS 580 Northern Ave. Hagers. MD 21740		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 30 / 80		23c. NAME OF CEMETERY OR CREMATORY Browns Mill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Antrim Twp. Franklin Co. Pa.	
24. FUNERAL DIRECTOR NAME A.E. Minnich - Greensboro, Pa.				25. DATE REC'D. BY REGISTRAR SEP 30 1980		25b. REGISTRAR'S SIGNATURE <i>A.E. Minnich</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

For the purpose of this investigation, the following information was obtained from the records of the Department of the Interior, Bureau of Land Management, and the Bureau of Reclamation, regarding the land ownership and management of the area.

The land in question is situated in the State of California, and is owned by the United States of America. It is a part of the public domain, and is subject to the laws and regulations of the Department of the Interior, Bureau of Land Management, and the Bureau of Reclamation.

The land is located in the County of [County Name], State of California, and is situated within the [Area Name] area. It is a part of the [Area Name] area, and is subject to the laws and regulations of the Department of the Interior, Bureau of Land Management, and the Bureau of Reclamation.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 4 3 2 3			
FOR 1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Joseph Frederick KEPLINGER				2a. DATE OF DEATH MONTH DAY YEAR Sept. 8, 1980		2b. HOUR 5:50 PM	
3 SEX male	4 RACE white	5. DATE OF BIRTH MONTH DAY YEAR November 17, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 84 86 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) farmer		12b. KIND OF BUSINESS OR INDUSTRY farming	
13a. STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11 S. Walnut St., Apt. 106	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin F. Keplinger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna J. Berg				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Charles Keplinger, Washington, D. C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>General Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10-20 yrs 10-20 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>① Hypochromic Anemia ② gastroenteritis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 5</u> , 19 <u>80</u> , to <u>Sept 8</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Sept 7</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death.							
22b. SIGNATURE <u>Edwaul W. Dittus III MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Sept 9, 1980</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>E.W. Dittus III MD</u>				22e. ADDRESS <u>217 W. Washington St. Hag. MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Sept. 11, 1980		23c. NAME OF CEMETERY OR CREMATORY Lahmansville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lahmansville, W. Va.	
24. FUNERAL DIRECTOR'S NAME <u>MINNICH FUNERAL HOME</u>				25. DATE REGISTERED <u>SEP 15 1980</u>			
415 E. Wilson Blvd., Hagerstown, Maryland 21740				25b. REGISTRAR'S SIGNATURE			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 4 3 2 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Harry Lawrence Knight			2a. DATE OF DEATH MONTH DAY YEAR 9/27/80			2b. HOUR 1:45 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 19 1919		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) General Manager Anril Products Co.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Penn		13b. COUNTY Franklin		13c. CITY OR TOWN State Line		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry C. Knight		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beulah G. Walker		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 187-01-5295	
17. INFORMANT ADDRESS Mrs Anna J. Knight State Line,							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of lung
1625
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

Congestive heart failure

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from Aug 19 78, to 9/27 19 80, that (1) (we) last saw the deceased alive on 9/26 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (do not) view the body after death.							
22b. SIGNATURE, Richard E. Smith, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/27/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Smith, M.D.				22e. ADDRESS 1708 Oak Hill Ave, Hagerstown, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/30/1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Antrim Twp Franklin Co Penna	
24. FUNERAL DIRECTOR NAME Harold E. Zimmerman				25. DAY RECEIVED BY REGISTRAR OCT 3 1980			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 4 3 2 5							
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH							
I. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Howard C. Lowe				September 26 1980				2 30 PM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH Aug. 28, 1887		6 AGE (IN YEARS LAST BIRTHDAY) 93		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10 CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Williamsport Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Agriculture			
13a. STATE W.Va.				13b. COUNTY Jefferson		13c. CITY OR TOWN Shepherdstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1	
14 FATHER'S NAME William H. Lowe				15. MOTHER'S MAIDEN NAME Mary Christine Virts							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 234-36-7179-4		17 INFORMANT Mrs. Catherine Small-Rt.1, Shepherdstown, W.V.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DOE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DOE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Sept 2, 19 80, to Sept 26, 19 80, that (I) (we) lost know the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.											
22b. SIGNATURE John R. Melnick						DEGREE M.D.		22c. DATE SIGNED 9-26-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Melnick, M.D.						22e. ADDRESS 16220 Frederick Rd. Gaithersburg, MD 20760					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 28, 1980		23c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Martinsburg, Berkeley, W.V.			
24. FUNERAL DIRECTOR NAME M. Brown - Martinsburg, W.Va.						25a. DATE REC'D. BY REGISTRAR SEP 29 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

(M)

Male

White

Age 28, 1927

93

September 16, 1950

Virginia

Washington

Williamsport

Williamsport Nursing Home

Former

Agriculture

W.V.

Williamsport, Pennsylvania

Route 1

William H. Lowe

Lowe

Mary

Christina

Virginia

No

27A-36-7179- Mrs. Catherine Smith-E.I. (Shoshone)

9-26-50

Funeral Home Funeral Home, Inc. - Martinsburg, Va.
Sept. 28, 1950 Rosedale Cemetery - Martinsburg, Westley, V.
34588 (M)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 4 3 2 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carl Edward LUSHBAUGH				2a. DATE OF DEATH MONTH DAY YEAR September 22, 1980		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 5, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Smithsburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Henrietta St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wood Worker		12b. KIND OF BUSINESS OR INDUSTRY Organ Works	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION): 13a. STATE Md.				13b. COUNTY Wash.		13c. CITY OR TOWN Smithsburg	
14. FATHER'S NAME FIRST MIDDLE LAST Fred - Lushbaugh				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude - Boward			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS Mrs. Cleona B. Lushbaugh, Smithsburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchiogenic Carcinoma with Metastasis of the Chest Wall.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH March 1979
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 10</u> , 19 <u>64</u> , to <u>Sept. 9</u> , 19 <u>80</u> , that <u>I</u> (we) last saw the deceased alive on <u>Sept. 9, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <u>I</u> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Charles F. Hess</u> M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/22/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. Hess, M.D.				22e. ADDRESS P.O. Box 248 Smithsburg, Md. 21783			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 24, 1980		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md.	
24. FUNERAL DIRECTOR NAME <u>Dennis L. Davis</u>				25a. DATE REC'D. BY REGISTRAR SEP 25 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL HOME Davis Funeral Home, Smithsburg, Md.							

BP

0 2 2 5



100% COTTON

100% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1629

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 4 3 2 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Frank John LYNCH				2a. DATE OF DEATH MONTH DAY YEAR September 3, 1980		2b. HOUR 4:35 M	
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR February 21, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) supervisor		12b. KIND OF BUSINESS OR INDUSTRY aircraft mfg.	
13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Lynch				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Milly Crouse			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 199-01-9833A		17. INFORMANT ADDRESS Mrs. Betty Lynch, Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma lung 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH month
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) diabetes pulmonary embolism							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 14, 1980 , to Sept. 3, 1980 , that (I) (we) last saw the deceased alive on Sept. 3, 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Gloria F. Puras				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/4/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLORIA F PURAS				22e. ADDRESS 382 Schuchman Ave.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Sept. 6, 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME				25. DATE REC'D. BY REGISTRAR SEP - 9 1980		25b. REGISTRAR'S SIGNATURE [Signature]	
415 E. Wilson Blvd., Hagerstown, Md. 21740							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 4 3 2 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Flora			FIRST MIDDLE LAST Magruder			2a. DATE OF DEATH MONTH DAY YEAR SEPT. 25 80			2b. HOUR 5:08 P.M.					
1. SEX F			4. RACE W			5. DATE OF BIRTH MONTH DAY YEAR June 24 1898			6. AGE (IN YEARS LAST BIRTHDAY) 82			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.					
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic			12b. KIND OF BUSINESS OR INDUSTRY Housewife					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. CITY OR TOWN Garrett			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. STREET ADDRESS Rt 1 Box 92 Westernport Md.					
14. FATHER'S NAME FIRST MIDDLE LAST John Green			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary McMillan											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-46-3649			17. INFORMANT ADDRESS William Magruder Rt1 Box 92 Westernport Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive HT Failure 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days YIS				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 1976 , 19____, to present , 19 80 , that (I) (we) last saw the deceased alive on 9/25/80 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Boal & Weeks			DEGREE Attending Physician			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Sept 29 '80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. N. Weeks			22e. ADDRESS 580 Western Ave Hagerstown Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/28/80			23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Westernport Allegany Md.					
24. FUNERAL DIRECTOR NAME Boal Funeral Service P. A.						ADDRESS Westernport Md.			25a. DATE REC'D BY REGISTRAR SEP 29 1980			25b. REGISTRAR'S SIGNATURE H. N. Weeks		



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 0 2 4 3 2 9		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Laban Horst Martin										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR Sept. 19, 80		2b. HOUR PM 1PM
3. SEX Male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Nov 18, 1896	6. AGE (IN YEARS) LAST BIRTHDAY 83 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR Sept. 19 1980		2d. HOUR PM 3:15				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co., MD.						
10. CITY OR TOWN OF DEATH Sandy Hook		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sandy Hook, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER & Carpenter		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Smithsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RD 2				
14. FATHER'S NAME FIRST MIDDLE LAST Michael W. Martin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Horst								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-12-1703		17. INFORMANT ADDRESS Edna M. Martin-Smithsburg, Md. R2								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) S-910 DROWNING DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:17 PM 1980			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) WHILE FISHING fell from rock						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Potomac River			21f. LOCATION STREET CITY OR TOWN COUNTY STATE no Sandy Hook WASH MD						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE H.N. Weeks			TITLE (SPECIFY) Dep			MEDICAL EXAMINER 580 Norton Ave			DATE SIGNED Sept 20 1980			
EXAMINER'S NAME (TYPE OR PRINT) H.N. Weeks			ADDRESS Hargetown MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/23/80		23c. NAME OF CEMETERY OR CREMATORY Reiff Cemetery			23d. LOCATION (CITY OR TOWN) COUNTY STATE Charlottesville, Wash. Co., Md.				
24. FUNERAL DIRECTOR NAME C.E. Mummel - Greencastle, Pa						25a. DATE REC'D. BY REGISTRAR SEP 23 1980		25b. REGISTRAR'S SIGNATURE History McLeod				



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 4 3 3 0

FOR
STATE
REGISTRAR

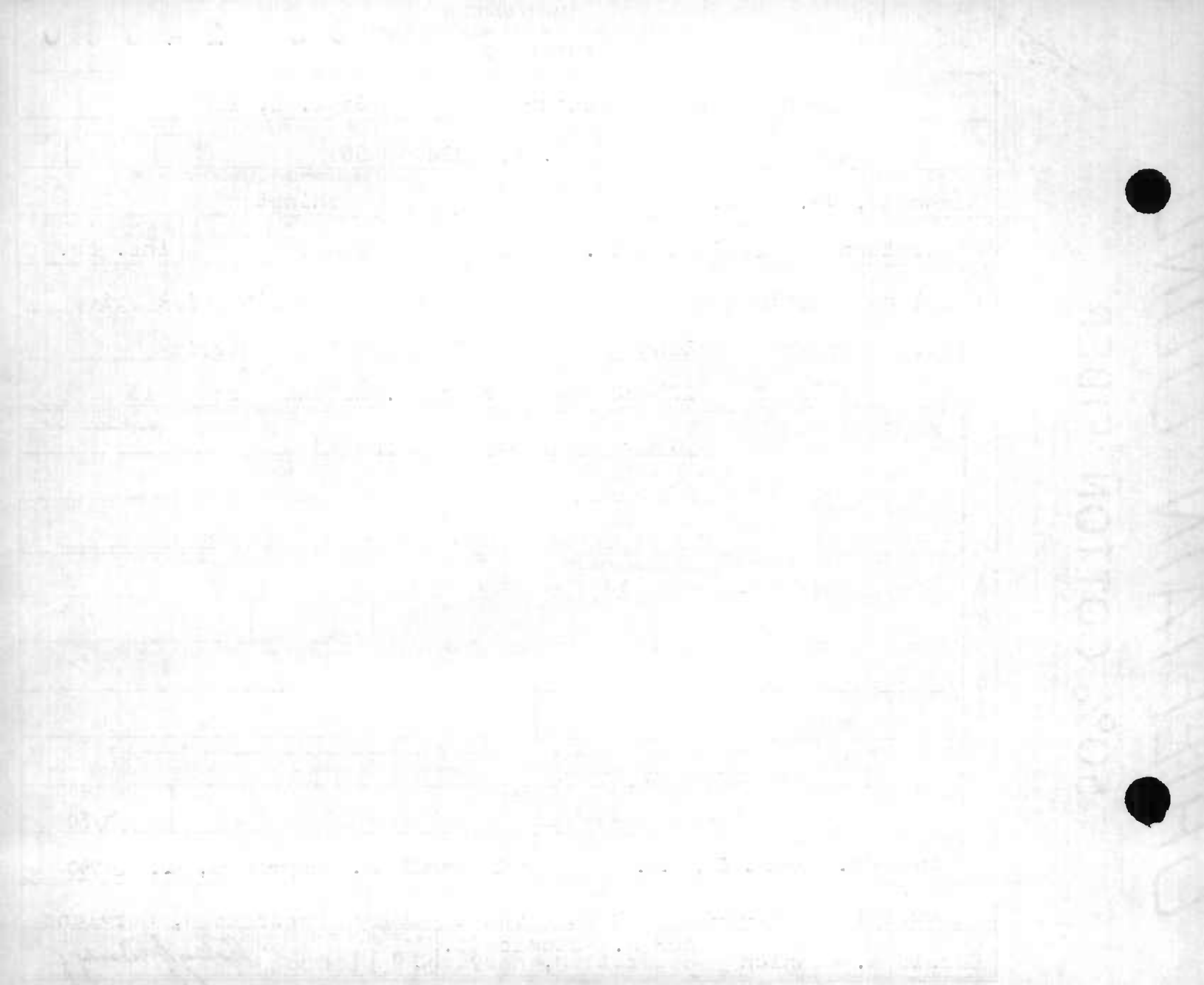
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Herman Warren McCann			2a. DATE OF DEATH MONTH DAY YEAR Sept. 2, 1980		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 1, 1924	6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Richmond, Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) owner	12b. KIND OF BUSINESS OR INDUSTRY ins. co.	
13a. STATE Maryland			13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Albert Robert McCann			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Nethiel Norris		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2	17. INFORMANT ADDRESS Barbara G. McCann see # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> <u>2000</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Histiocytic lymphoma - stage IV</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pancytopenia secondary to chemotherapy</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>George Newman II</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/3/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George C. Newman, II, M.D.		22e. ADDRESS 1825 Howell Rd. Hagerstown, MD. 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9-4-80	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Maryland	
24. FUNERAL DIRECTOR NAME Gerald N. Minnich		305 N. Potomac St. Hagerstown, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 11 1980	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 4 3 3 1	
FOR STATE REGISTRAR		7								REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Laura Virginia MC KEON						2a. DATE OF DEATH MONTH DAY YEAR September 11, 1980			2b. HOUR 10:55 P M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 19, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Shepherdstown, W. Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Readers Memorial Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Florist		12b. KIND OF BUSINESS OR INDUSTRY Floral Design			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince Geo.						13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8605 Lantern Lane	
14. FATHER'S NAME FIRST William MIDDLE LAST Muck				15. MOTHER'S MAIDEN NAME FIRST Ziphora MIDDLE LAST Mc Coy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 4140		17. INFORMANT ADDRESS Mrs. Mildred A. Bromley, 8605 Lantern Lane Clinton, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASVD, Coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHF</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>1 wk</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c): <u>Osteoarthritis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>October 21</u> , 19 <u>77</u> , to <u>Sept. 11</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Charles R. Wierner MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9-12-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES R. WIERER, M.D.				22e. ADDRESS Box 173, Myersville, Md., 21773							
23a. BURIAL, CREMATION, REMOVAL (SEE INSTRUCTIONS) Burial		23b. DATE 9-15-80		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Boonsboro, Wash. Co., Md.					
24. FUNERAL DIRECTOR NAME John H. Bast, Jr. ADDRESS Boonsboro, Md. 21713						25a. DATE REC'D. BY REGISTRAR SEP 15 1980		25b. REGISTRAR'S SIGNATURE <u>Rita McBrady</u>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 24332		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Samuel Alexander Mc Loughlin										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR Sept 27 1980		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR April 6, 1925		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 55		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR Sept. 27 1980		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) attorney		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Vermont			13b. COUNTY Chittenden		13c. CITY OR TOWN Ferrisburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Spear Street, Ext.			
14. FATHER'S NAME FIRST MIDDLE LAST George McLoughlin						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II 145-16-1141			17. INFORMANT ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing E-918 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Motor vehicle non-traffic accident E-821 DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH instant												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Callapse from cardiac event 410												
19a. DATE OF OPERATION NA			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:20 P.M. 9-27 1980			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Collapsed and fell under wheels of tractor at tractor pull.						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Smithsburg Park			21f. LOCATION STREET CITY OR TOWN COUNTY STATE Smithsburg, Washington, Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE Harold R Tritch Jr						TITLE (SPECIFY) deputy			DATE SIGNED Sept 29, 1980			
EXAMINER'S NAME (TYPE OR PRINT) Harold Tritch, Jr. M.D.						ADDRESS 138 E. Antietam St. Hagerstown Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Oct. 2, 1980		23c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Charlotte, Vermont				
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740						25a. DATE REC'D. BY REGISTRAR OCT 3 1980		25b. REGISTRAR'S SIGNATURE [Signature]				

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

TO : SAC, NEW YORK (100-100000)
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]

[Illegible text block]

[Illegible text block]

[Illegible text block]

[Illegible text block]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 4 3 3 3 REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) BETSY JEAN METZ				2a DATE OF DEATH MONTH DAY YEAR Sept. 6, 1980				2b HOUR 6:03P M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Sept. 25, 1945		6 AGE (IN YEARS LAST BIRTHDAY) 34 YRS.		7 UNDER 1 YEAR MONTHS DAYS 0 0		7 UNDER 24 HRS HOURS MIN. 0 0	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.					
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Homemaker			
13a STATE Maryland				13b COUNTY Washington		13c CITY OR TOWN Chestnut Grove		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST Ernest William Dodson				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie Elizabeth Jenkins				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b SOCIAL SECURITY NO. 232-72-9391				17 INFORMANT Lloyd J. Metz - Husband				17 ADDRESS Route 1, Box 283C Harpers Ferry, W V			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uterine carcinoma 1809 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stage IV Carcinoma of Cervix DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 8/15, 1980 to 9/6, 1980 , that (I) (we) first saw the deceased alive on 9/6, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE John R. Marsh				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 9/8/80			
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHN R. MARSH, M.D.				22e ADDRESS 239 N. POTOMAC STREET HAGERSTOWN, MD 21740							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE 9/9/80		23c NAME OF CEMETERY OR CREMATORY Samples Manor Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Samples Manor, Maryland			
24 FUNERAL DIRECTOR NAME Robert L. Spencer				ADDRESS P. O. Box 446 Harpers Ferry, W V		25a DATE RECEIVED BY REGISTRAR SEP 15 1980		25b REGISTRAR'S SIGNATURE Henry McCurdy			

BP



SEP-11-1980

SEP 11 1980

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 4 3 3 4			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Irene Helen Moleskie								Sept 10 1980					4:45 AM
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS			
female		white		Dec. 15, 1901		73 YRS		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
Austria		U.S.A.				Washington MD							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Washington County Hospital						Housewife		Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		300 Cornell Ave.			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Simon				Pearl									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS							
no				183-12-7960		Bernard W. Moleskie 110 Reynolds Ave. Hag.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease												10 yrs	
3506 DUE TO, OR AS A CONSEQUENCE OF (b) Arterio Sclerotic Cardiovascular Disease												10 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus												10 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)													
Mid thigh Amputation Left Leg													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
Sept 8 1980		Gangrene Left leg				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
		P.M. 19											
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21g. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6 Sept 19 80 to 10 Sept 19 80, that (I) (we) last saw the deceased alive on 9 Sept 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE				22c. DATE SIGNED							
Frank E Brumback MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				10 Sept 1980							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Frank E Brumback		119 King St Hagerstown Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		9/12/80		Greenlawn Memorial		Williamsport		Washington		MD			
24 FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Osborne Funeral Home P.O.Box 348 Wmspt., MD		SEP 22 1980				mofsky/maloney							

BP



276 S. 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 4 3 3 5 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Rosie Lee Morris						2a. DATE OF DEATH MONTH DAY YEAR September 29, 1980				2b. HOUR M 	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR July 1, 1897		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 83		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Coffman Home for the Aged				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) domestic		12b. KIND OF BUSINESS OR INDUSTRY home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Walnut Towers					
14. FATHER'S NAME FIRST MIDDLE LAST John - - Tracey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha - - (unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220 30 9634		17. INFORMANT ADDRESS Mrs. Julia Grantland Hagerstown, Md. 1113 Woodland W.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thromboses. 2500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebro Vascular Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1978 1979+ 1978+	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic Heart Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (did) (viewed) the deceased from MAY 6 , 19 78 , to SEPT 29 , 19 80 , that (I) (was) last saw the deceased alive on OCT 27 , 19 80 , and that in (my) (an) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) view the body after death.											
22b. SIGNATURE Gerald A. Minnich				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/30/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gerald A. Minnich				22e. ADDRESS 1147 0212 Hill Ave. Hagerstown							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-1-80		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Maryland			
24. FUNERAL DIRECTOR NAME Gerald N. Minnich				ADDRESS 305 N. Potomac St. Hagerstown, Maryland				25a. DATE REC'D. BY REGISTRAR OCT 10 1980		25b. REGISTRAR'S SIGNATURE Robert McCreary	

BP

2001

1234

59

1993

2

7545

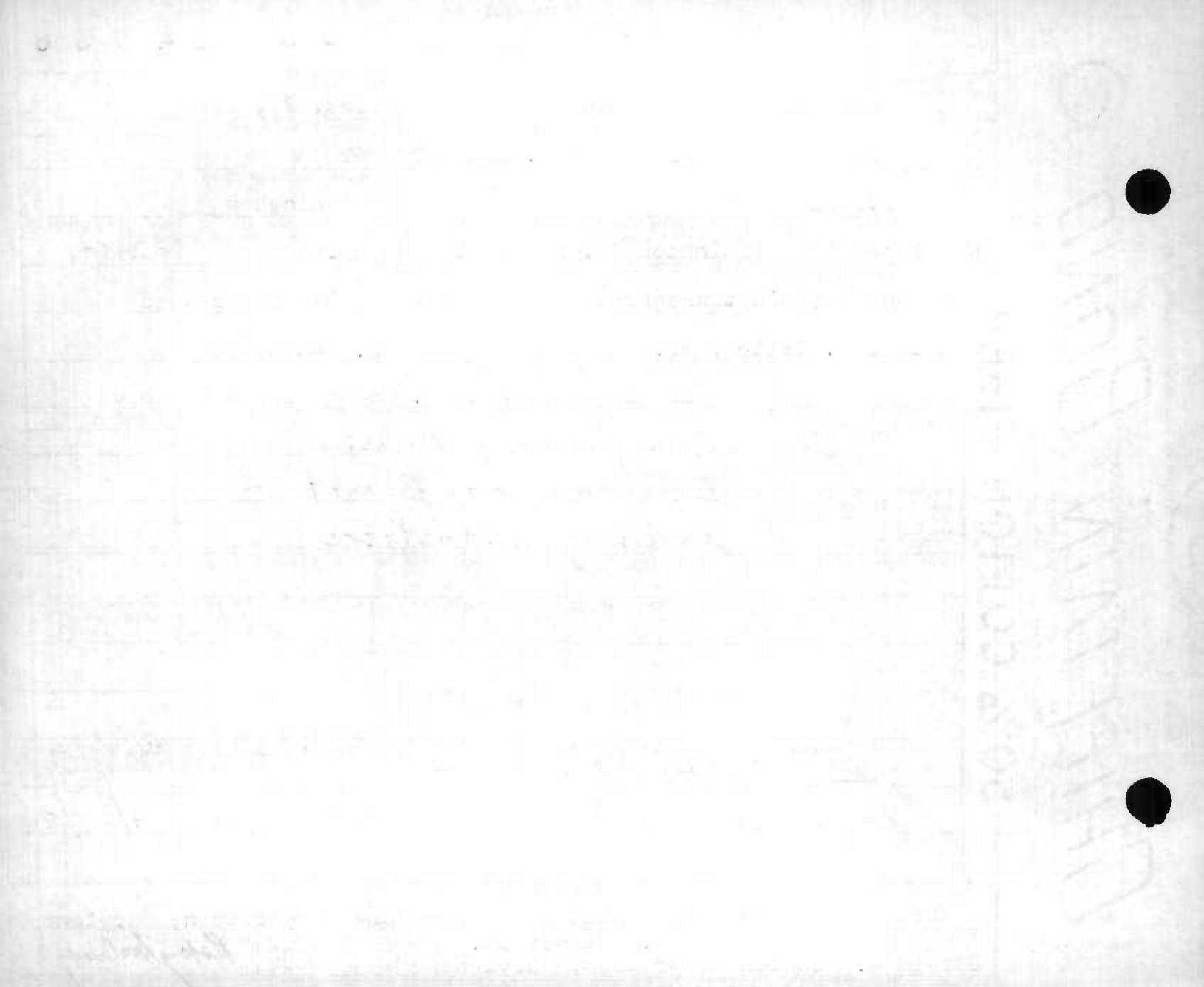


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 4 3 3 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rosella Mae Mowen				2a. DATE OF DEATH MONTH DAY YEAR Sept. 27, 1980			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 12, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) nurse		12b. KIND OF BUSINESS OR INDUSTRY nursing	
13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown	
14. FATHER'S NAME FIRST MIDDLE LAST Harold R. Tritch, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura L. Whitmore			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220 22 8153		17. INFORMANT ADDRESS Donald R. Mowen see # 13 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 1749 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Breast</u> (c) <u>Cerebral metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>10/1</u> , 19 <u>79</u> , to <u>9/27</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9/27</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did not) view the body after death.							
22a. SIGNATURE <u>George Newman II</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/29/80	
22b. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-29-80		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Maryland	
24. FUNERAL DIRECTOR NAME Gerald N. Minnich Hagerstown, Maryland				305 N. Potomac St. ADDRESS		25a. DATE REC'D. BY REGISTRAR OCT 2 1980	
				25b. REGISTRAR'S SIGNATURE <u>History McCreedy</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 4 3 3 7 REG. NO.			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mildred Patricia MYERS						2a. DATE OF DEATH MONTH DAY YEAR September 14, 1980				2b. HOUR 10:30AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 11, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 50		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chestnut Grove, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.							
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 105 E. Franklin St.					
14. FATHER'S NAME FIRST MIDDLE LAST Joe Bussard				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beulah Holmes				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 220-26-0146	
17. INFORMANT ADDRESS Mr. Arthur H. Myers, Hagerstown, Md. 21740													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF (b) WITH METASTASIS TO THE PUBIS DUE TO, OR AS A CONSEQUENCE OF (c) AND RIGHT THIGH CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6/18 , 19 66 to 9/14 , 19 80 , that (I) (we) lost saw the deceased alive on 9/13 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Amarello</i>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/16/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. AMARILLO				22e. ADDRESS 127 KING ST. HAGERSTOWN MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9-17-80		23c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Samples Manor, Hagerstown, Md.					
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.						ADDRESS Boonsboro, Md. 21713		25a. DATE RECEIVED BY REGISTRAR SEP 18 1980		25b. SIGNATURE <i>Patricia Myers</i>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 4 3 3 8	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Sallie Amelia Newcomer					Sept 3 1980					M	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female	White	August 14, 1893			87		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Beaver Creek, Md.	U. S. A.				Washington MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown	Washington County Hospital				Housewife		Own Home				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS				
13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rfd. 1				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
Charles E. Scadden					Betty Bowers						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No					219-20-0701		Mr. Miles O. Scadden, Rfd. 1 21740 Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cardiac failure</u>										3 mo	
4148 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u>										years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerosis C VII</u>										years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Acute myocardial infarction Oct 19 - undetermined</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>20 Oct 19 70</u> to <u>date</u> 19 <u>70</u> , that (I) (we) lost <u>the deceased</u> on <u>3 Sept 80</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE					DEGREE			22c. DATE SIGNED			
Richard T. Binford, M.D.					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			3 Sept 80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
Richard T. Binford, M. D.					1135 Potomac Ave, Hagerstown, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			9- 6- 80		Beaver Creek Cemetery			Beaver Creek, Wash. Co., Md.			
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
John H. Bast, Jr.					Boonsboro, Md. 21713			SEP 5 1980			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 4 3 3 9		
1. FOR STATE REGISTRAR			REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
Mary Louise PALMER						9/5/80						8:20a
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Female			White		6/22/43		37		YRS.		MONTHS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH						
Pennsylvania			U.S.A.			Washington County			MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown			Western Maryland Hospital Center			management			business machine mfg.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13d. STREET ADDRESS			
Maryland			Frederick			Frederick			Route 1, Box 426			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
David L. Brode			Mary Iprana Kreiger									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS						
NO			213-40-3372			Douglas Palmer, Rt.1, Box 426, Fred., Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u>										One week		
1919 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recurrent glioblastoma multiforme with metastasis.</u>										1978		
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
			HOUR A.M. MONTH DAY YEAR									
			P.M. 19									
21d. INJURY OCCURRED			21e. PLACE OF INJURY		21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from <u>August 26</u> , 19 <u>80</u> , to <u>September 5</u> , 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>September 5</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE			DEGREE				22c. DATE SIGNED					
<u>Fe U. Porciuncula M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				<u>Sept 5, 1980</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
Fe U. Porciuncula, M.D.			1500 Pennsylvania Ave., Hagerstown, MD									
23a. BURIAL, CREMATION, REMOVAL			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
burial			Sept. 8, 1980		Cedar Lawn Mem. Park		Hagerstown, Wash., Maryland					
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
MINNICH FUNERAL HOME			1415 E. Wilson Blvd., Hagerstown, Md. 21740				SEP 15 1980 <u>History</u>					

2 4 3 3 7

8:00a. 25/50 27 3 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

Washington County

Marion, Oregon

One week

September 2, 1900

SEP 12 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 4 3 4 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Wilbur Patterson			2a. DATE OF DEATH MONTH DAY YEAR September 15, 1980			2b. HOUR M M				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR March 8, 1916		6 AGE (IN YEARS LAST BIRTHDAY) YRS 64		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, Md.				
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ord. Depot		12b. KIND OF BUSINESS OR INDUSTRY Military		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland			13c. COUNTY Washington		13d. CITY OR TOWN Hagerstown		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS 316 Summit Avenue	
14 FATHER'S NAME FIRST MIDDLE LAST Merle A. Patterson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna C. Zeigler Carey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) Army WW II		17 INFORMANT ADDRESS John Zeigler					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from April 15, 1980 , to Sept 15, 1980 , that (I) (we) lost saw the deceased above, Sept 14, 1980 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE L Waldron M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/15/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L WALDRON M.D.			22e. ADDRESS 138 E Antietam St							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-24-80		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Md.		
24 FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hag., Md.			ADDRESS Rest Haven Funeral Chapel, Inc., Hag., Md.			25a. RECEIVED BY REGISTERAR SEP 23 1980		25b. REGISTERAR'S SIGNATURE <i>[Signature]</i>		

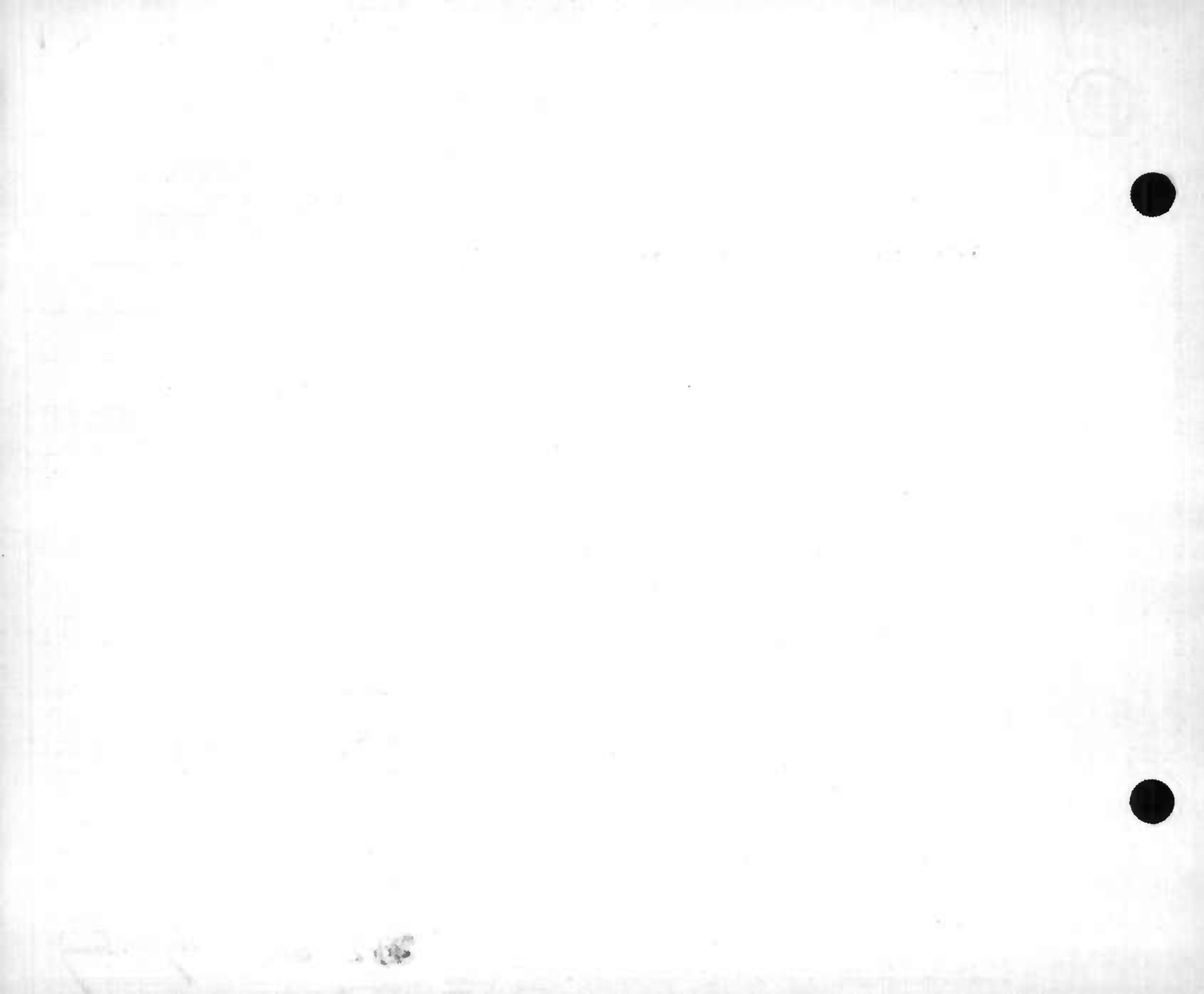
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80 24341	
1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bertha Susan Pitsnogle				2a DATE OF DEATH MONTH DAY YEAR 9-22-80			2b HOUR M		
3 SEX F		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 6 9 1895		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa		7b CITIZEN OF WHAT COUNTRY? USA		9 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Maugansville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
14 FATHER'S NAME FIRST MIDDLE LAST George F. Tressler				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah E. Ledy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-32-6002		17 INFORMANT ADDRESS William H. Pitsnogle, Hagerstown, Md.							
18 CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE GRAM-NEGATIVE SEPTICEMIA</u> 0384 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>DIABETIC KETO-ACIDOSIS</u>											
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 18</u> 19 <u>80</u> , to <u>SEPTEMBER 22</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>SEPTEMBER 22</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Barry M. Cohen</u>				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-22-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY M. COHEN				22e. ADDRESS 1148 KENLY AVE HAGERSTOWN, MD, 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Sept. 25, 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem Park		23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland		COUNTY		STATE	
24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME				25a. DATE OF REGISTRATION BY REGISTRAR SEP 26 1980		25b. REGISTRAR'S SIGNATURE <u>Robert McCuskey</u>					
415 E. Wilson Blvd., Hagerstown, Md. 21740											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ENCOUNTERED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR 115 ME (5))
15M7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
FIRST MIDDLE LAST William Everrett Quinn			MONTH DAY YEAR Sept. 19, 80			AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR	
Male	White	MONTH DAY YEAR Dec. 27, 1934	45 YRS.	MONTHS DAYS	HOURS MIN	Sept 19, 80	2:55 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		
West Virginia			U.S.A.			Washington MD.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		
			Hagerstown			38 East Franklin Street		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
maintenance			Public Bldg.					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland			Washington			Hagerstown		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Ralph Quinn			Gladys Lamn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
no			273-32-7265			Marsha Quinn, Hagerstown, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>414 Myocardial Infarction</u> 410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
			M.D. Deputy			Sept. 20, 1980		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Howard N. Weeks, M.D.P.A.			580 Northern Ave. Hagers. MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			Sept. 22, 1980		Hacker Valley Cemetery		Hacker Valley, West Virginia	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Minnich Funeral Home			415 E. Wilson Blvd., Hagerstown, Maryland 21740			SEP 24 1980		



1000 1893

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO. 8 0 2 4 3 4 3				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST / Mary Rosetta Renner					2a. DATE OF DEATH MONTH DAY YEAR September 22, 1980			2b. HOUR 8:30A _M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 11, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hancock		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 239 Maryland Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hancock					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 239 Maryland Avenue		
14. FATHER'S NAME FIRST MIDDLE LAST Frank nmi Burnett, Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine nmi Graham				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219 20 4660		17. INFORMANT ADDRESS Mrs. Mary F. Grimes Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASHD and Hypertension</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 years one month									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Stroke 9-24-74									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (Name of Hospital) attended the deceased from 11-4- to 9-15-1980, that (I) (we) lost saw the deceased alive on 9-15-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE FB Thomas III M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-23-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank B. Thomas, III, M.D.				22e. ADDRESS Two Tonoloway, Hancock, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-24-1980		23c. NAME OF CEMETERY OR CREMATORY St. Thomas Episcopal Hancock, Washington, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Richard J. Love				ADDRESS Hancock MD		25a. DATE REC'D. BY REGISTRAR SEP 29 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

0007 10 236

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 80 24344			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Mary Margaret Rice</i>				2b. DATE OF DEATH MONTH DAY YEAR <i>9-5-80</i>			
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>Sept. 22, 1910</i>		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <i>69</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Penna</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington Co.</i> MD.	
10 CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Co. Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>House work</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i>	
13a. STATE <i>Penna</i>		13b. COUNTY <i>Franklin</i>		13c. CITY OR TOWN <i>Greencastle</i>		13d. STREET ADDRESS <i>RD #4</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Harry E. Mayhugh</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary B. Mowen</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR (UNUSUAL)) <i>No</i>				16b. SOCIAL SECURITY NO <i>198-34-6315</i>			
17 INFORMANT <i>Preston Rigg, RD #4, Greencastle Pa</i>				ADDRESS <i>RD #4, Greencastle Pa</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4140</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Myocardial Infarction</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>9-5-80</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>Home</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>RD #4, Greencastle Pa</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>9-5-80</i> , 19 <i>80</i> , to <i>9-5</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>9-5-80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>E. R. Lindeloh</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>9-5-80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. R. Lindeloh</i>				22e. ADDRESS <i>381 South Howard, Hagerstown</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9/7/1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Beautiful View Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>State Lines Washington Md</i>	
24 FUNERAL DIRECTOR NAME <i>Harold H. Zimmerman</i>				ADDRESS <i>Greencastle, Pa</i>		25a. REG'D. BY REGISTRAR <i>SEP 10 1980</i>	





SEP 10 1990

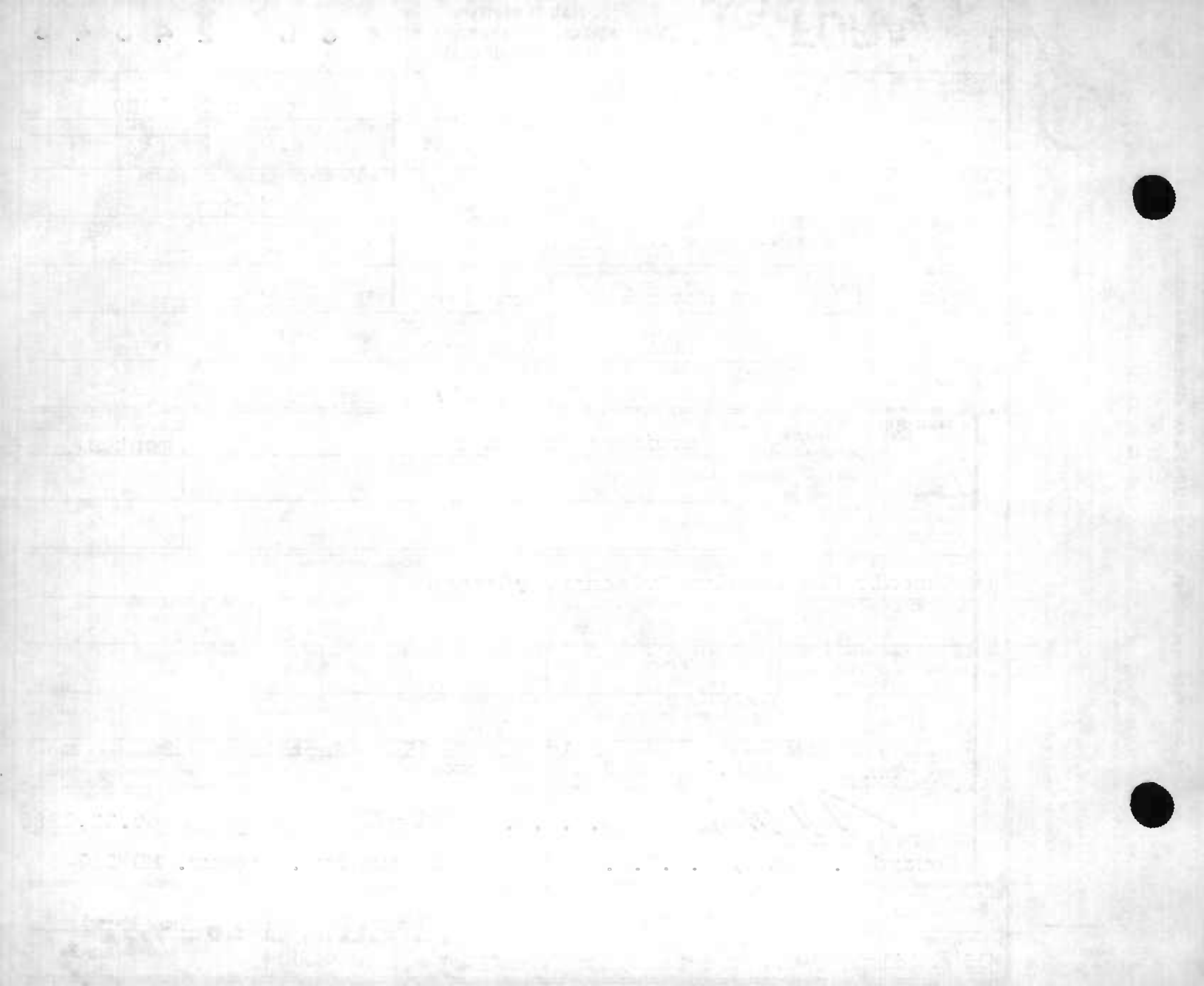
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 4 3 4 5			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mearl Rankin RICE				2a. DATE OF DEATH MONTH DAY YEAR September 20, 1980		2b. HOUR M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 5, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 211 West Side Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) inspector		12b. KIND OF BUSINESS OR INDUSTRY railroad	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Rice				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Kline			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO 220-09-9397		17. INFORMANT ADDRESS Mrs. Lola E. Rice, Hagerstown, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of lungs DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE 1629							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic Obstructive Pulmonary Disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) XXXXXX attended the deceased from July 19 65 to Sept 19 19 80 that (I) XX last saw the deceased alive on Sept. 19 19 80, and that in (my) XXX opinion death occurred on the date and hour and from the causes stated above, (I) XXX (did not) view the body after death.							
22b. SIGNATURE  M.D.P.A. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>				22c. DATE SIGNED Sept. 22, 1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard N. Weeks, M.D.P.A.				22e. ADDRESS 580 Northern Ave. Hagers. MD 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 23, 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740				25a. DATE REC'D. BY REGISTRAR SEP 25 1980		25b. REGISTRAR'S SIGNATURE 	

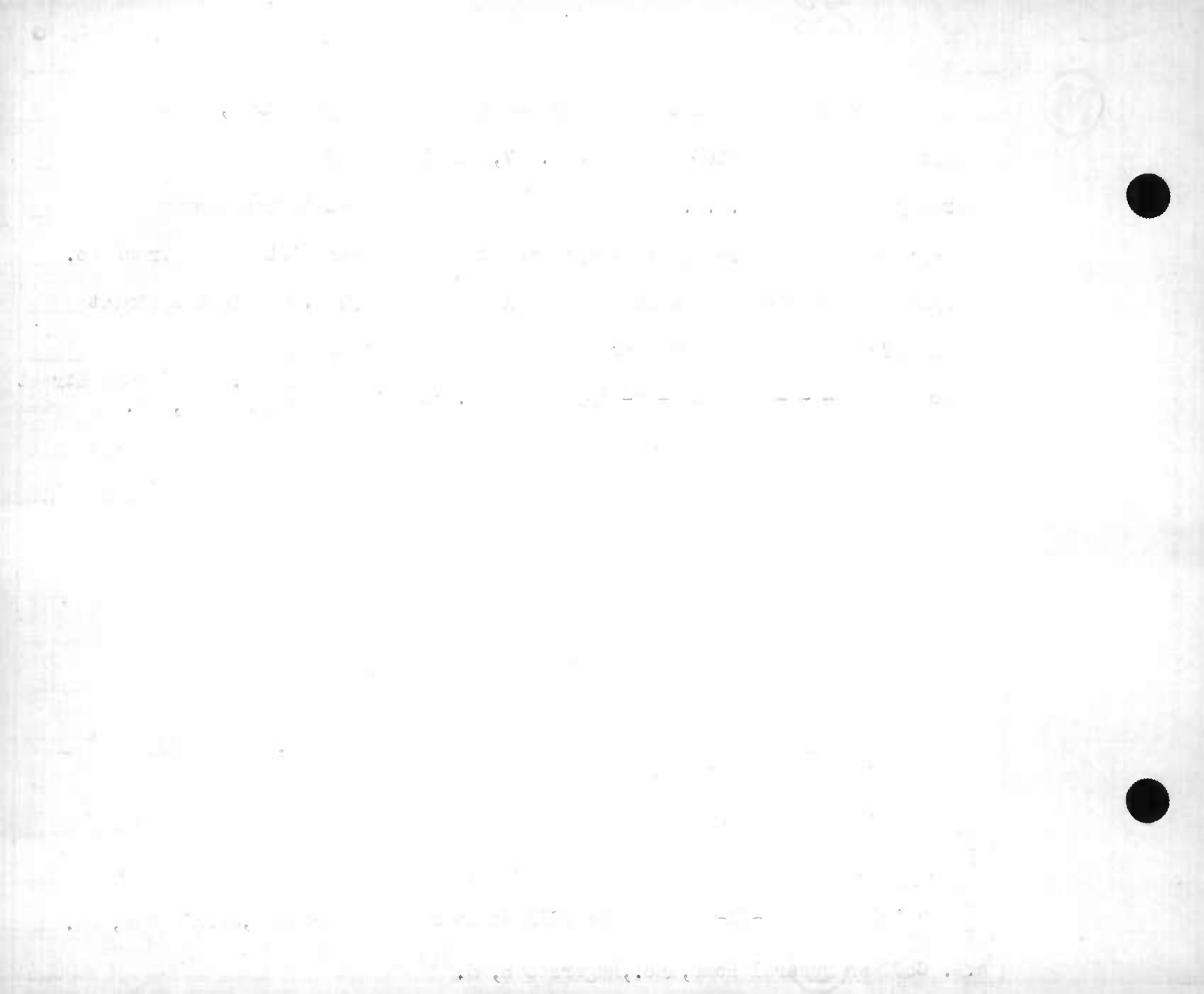


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 4 3 4 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) John Hans Ronneberg				2a. DATE OF DEATH MONTH DAY YEAR September 9, 1980			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Jan. 7, 1912		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Truck Co.	
13a. STATE Maryland				13b. CITY OR TOWN Hagerstown		13c. STREET ADDRESS 837 W. Washington Street	
14 FATHER'S NAME FIRST MIDDLE LAST Adolf Ronneberg				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 132-10-7935		17 INFORMANT Alma E. Ronneberg		ADDRESS 837 W. Washington Street Hagerstown, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CACHEXIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA OF LARYNX</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Wks.</u> <u>1 yr.</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>10/8</u> , 19 <u>83</u> , to <u>9/9</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9/8</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>Harold R. Tritch, Jr.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/10/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harold R. Tritch, Jr., M.D.				22e. ADDRESS 138 E. Antietam St., Hagerstown, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-12-80		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Washington, Md.	
24 FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md.				25. DATE REC'D BY REGISTRAR SEP 15 1980			



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IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

FOR 1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
		Mary Johnston Saum		Sept.		17		1980		10:00A		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.			
Female		White		April 25 1889		91 YRS.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Penna.		U.S.A.				Washington Co.						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown		Washington Co. Hospital		Housewife									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Penna.		Franklin		Waynesboro		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11417 Lower Edgemont Road					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
John A. Johnston		Mary Brown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		214-09-4049D		Robert J. Saum		Box 340 R.D. #1 Hagerstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		PROBABLE BOWEL OBSTRUCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		DAYS					
2500		DUE TO, OR AS A CONSEQUENCE OF		(b) A. S. C. V. D.		YEARS							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF		(c) DIABETES MELLITUS		YEARS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET									
22a. I certify that (1) (this hospital) attended the deceased from 9/17/80 to 9/17/80, that (1) (we) last saw the deceased alive on never 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. If we (did) did not view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
		Charles R. Chaney M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		9/17/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Charles R. Chaney		119 King St., Hagerstown, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
Burial		9/20/1980		Harbaugh's Cemetery		Waynesboro, Pa.		Franklin		Pa.			
24. FUNERAL DIRECTOR		25. ADDRESS		26. REGISTRAR'S SIGNATURE									
David Y. Lure		50 S. Broad St. Waynesboro, Pa.		SEP 23 1980									

MEDICAL CERTIFICATION



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 4 3 4 8			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>Gloria Jean Schindell</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>Sept 5 1980</u>		2b. HOUR <u>8 20 AM</u>	
3 SEX <u>female</u>		4 RACE <u>white</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>Dec. 26, 1922</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>57</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington</u> MD.	
10 CITY OR TOWN OF DEATH <u>Hagerstown</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington County Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE <u>Maryland</u> 13b. COUNTY <u>Washington</u> 13c. CITY OR TOWN <u>Hagerstown</u>			
14 FATHER'S NAME FIRST MIDDLE LAST <u>Stanley E. Everhart</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Ann C. Barr</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS <u>Caroleen J. Ekberg, Renton, Wash.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock.</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>2 days</u> <u>years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (10)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>19 76</u> to <u>Sept 5</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>Sept 5</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE <u>[Signature]</u> DEGREE <u>M.D.</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Sept 5, 1980</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		23b. DATE <u>Sept. 8, 1980</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Hagerstown, Wash., Maryland</u>	
24 FUNERAL DIRECTOR NAME <u>MINNICH FUNERAL HOME</u> ADDRESS <u>415 E. Wilson Blvd., Hagerstown, Md. 21740</u>				25a. DATE REC'D BY REGISTRAR <u>SEP 15 1980</u> REGISTRAR'S SIGNATURE <u>[Signature]</u>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 4 3 4 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Marry Virginia Sharer				2a. DATE OF DEATH MONTH DAY YEAR August 20, 1980			
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR March 28, 1894		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 126 Ray St. Hagerstown, MD 21740		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Kitchen Helper		12b KIND OF BUSINESS OR INDUSTRY Restaurant	
13a STATE Maryland		13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST William H. Shipley		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Urilla Hammond		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-24-7814	
17 INFORMANT Sarah Hendricks		ADDRESS 126 Ray St. Hag., MD 21740		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Hypertensive Heart Disease</u> <u>yes</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Essential hypertension</u> <u>yes</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (the hospital) attended the deceased from <u>7-13</u> 19 <u>80</u> , to <u>8-10</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>8-10</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>W. B. Kang, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>8-20-80</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>W. B. KANG</u>				22e ADDRESS <u>1933 Va. Ave. Hagerstown, Md</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Aug. 23, 1980		23c NAME OF CEMETERY OR CREMATORY Greenlawn Mem. Park		23d LOCATION CITY OR TOWN COUNTY STATE Williamsport Washington MD	
24 FUNERAL DIRECTOR NAME Osborne Funeral Home P.O. Box 348 Wmspt., MD				25 DATE RECEIVED BY REGISTRAR SEP 20 1980			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 4 3 5 0	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Roger Ray SINNISEN						2a. DATE OF DEATH MONTH DAY YEAR September 15, 1980		2b. HOUR 5:30A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 17, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 87		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Frederick Co., Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 310 N. Cannon Ave.				12a. USUAL OCCUPATION (TYPE OR WORK FORMERLY OF WORKING LIFE) Furniture Crater		12b. KIND OF BUSINESS OR INDUSTRY Furn. Mfg.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 928 Chestnut St.			
14. FATHER'S NAME FIRST MIDDLE LAST Sheridan Upton Sinnisen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Florence Poffenberger							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-26-7246		17. INFORMANT ADDRESS Mr. Richard R. Sinnisen, Keedysville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410 - Probable acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiac Os. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Diabetes mellitus, Chronic SOB, Pulm. Os. - Recent bronchitis										APPROXIMATELY BETWEEN ONE 21-55 YEARS	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) XXXXXX attended the deceased from 13 Dec , 19 72 , to date , 19 80 , that (I) XX lost saw the deceased die on 12 Sept. , 19 80 , and that (my) XX opinion death occurred on the date and hour and from the causes stated above. (If (XX) lost, did not view the body after death.)										22c. DATE SIGNED 16 Sept. 80	
22b. SIGNATURE Richard T. Binford				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard T. Binford, M.D.				22e. ADDRESS 1135 Potomac Ave., Hagerstown, Md. 21740			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 9-18-80		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash Co., Md.					
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.,				ADDRESS Boonsboro, Md. 21713		25a. DATE REC'D. BY REGISTRAR SEP 18 1980		25b. SIGNATURE John H. Bast, Jr.			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR Robert Edward Slick									
1 DECEASED NAME (TYPE OR PRINT) Robert Edward Slick						7a. DATE OF DEATH Sept 16 1980		7b. HOUR 11³⁵ P	
3 SEX Male		4 RACE White		5. DATE OF BIRTH Sept. 9, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		8 IF UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steam Fitter		12b. KIND OF BUSINESS OR INDUSTRY Plumbing	
13a STATE Maryland		13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 151 W. Washington Street	
14 FATHER'S NAME Albert J. Slick				15 MOTHER'S MAIDEN NAME Nellie Rouskulp					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 214-09-0548		17 INFORMANT Helen J. LeFerve ADDRESS 807 View Street Hagerstown, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident 436- DUE TO, OR AS A CONSEQUENCE OF Brain Stem Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY 9-16 1980 HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 9-16 1980 to 9-16 1980 , that (I) (we) lost saw the deceased alive on 9-16 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Charles E. Spencer M.D. DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c DATE SIGNED 9-17-80			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Charles E. Spencer M.D.				22e ADDRESS 1198 Kenley Drive, Hagerstown, Md.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-19-80		23c NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Md.			
24 FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md.				24b ADDRESS		25a DATE REC'D. BY REGISTRAR SEP 22 1980 REGISTRAR'S SIGNATURE H. J. LeFerve			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 4 3 5 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Doris Evans Smead				2a. DATE OF DEATH MONTH DAY YEAR 9/10/1980		2b. HOUR 4:15 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 26 1914		6. AGE IN YEARS LAST BIRTHDAY 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Furniture	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Washington Hagerstown				14. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15. STREET ADDRESS 1134 Oak Hill Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Eugene Evans				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Lang			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO.			
17. INFORMANT Edwin Smead, Hagerstown, Md.				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest 4234 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c) CONTRIBUTING CAUSE (a), (b), or (c) stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 3 months.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cancer of breast							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from February 1978 to Sept 10 1980 , that (II) (we) lost saw the deceased alive on Sept 10 1980 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (III) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard E. Smith, M.D.				DEGREE M.D.		22c. DATE SIGNED 9/10/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Smith, M.D.				22e. ADDRESS 1708 Oak Hill Ave., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Sept. 13, 1980		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME				25a. DATE REC'D. BY REGISTRAR SEP 15 1980		25b. REGISTRAR'S SIGNATURE Henry McCreedy	
415 E. Wilson Blvd., Hagerstown, Md. 21740							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1- FOR STATE REGISTRAR		Jessie Viola Smith								80 24353	
1 DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
Jessie V. Smith								9/18/80		6 ¹⁵ A.M.	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN	
Female		White		9/15/80		90 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Franklin Co. Pa.		U.S.A.				Washington MD.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Hagerman Manor Nursing Home						Ribbon Winder		Ribbon Factory	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS			
Maryland		Washington		Hagerstown				442 North Prospect Street			
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Abraham L. Smith				Rebecca F. Bonebrake							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS					
No		214-09-3353		Maude S. Smith		Hagerstown, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest											
438- DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Old Cerebrovascular accident											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (the hospital) attended the deceased from 6-3, 1980, to 9-18, 1980, that (I) (we) last saw the deceased alive on 7-14, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		DEGREE				ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED			
Lloyd A. Hoffman		M.D.						9/18/80			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS									
Lloyd A. Hoffman		1142 22nd Hill Ave. - Hagerstown, Md.									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
Burial		9-22-80		Rose Hill Cemetery		Hagerstown Washington Md.					
24 FUNERAL DIRECTOR NAME ADDRESS											
A.K. Coffman Funeral Home, Inc., Hagerstown, Md.											

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 0 2 4 3 5 4		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Naomi Smith				2a. DATE OF DEATH MONTH DAY YEAR 9/17/80		2b. HOUR 2:45 P.M.			
3 SEX F		4 RACE W.		5 DATE OF BIRTH MONTH DAY YEAR October 8, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Frederick Co., Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hosp. (W)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY Frederick 13c. CITY OR TOWN Middletown				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rfd. 1 Box 145			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Reeder				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Poffenberger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 213-74-6446		17. INFORMANT ADDRESS Rfd. 1 Box 145 Mr. Elmer V. Smith, Middletown, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carbon monoxide</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>arteriosclerotic heart disease</u> (c) <u>congestive heart failure</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-6 weeks years 1 month	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>For carcinoma to bladder - Diabetes mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9-12</u> , 19 <u>80</u> , to <u>9-16</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9-16</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Joseph Secondary</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9-17-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH SECONDARY				22e. ADDRESS Boonsboro, Md 21713					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-20-80		23c. NAME OF CEMETERY OR CREMATORY Boonsboro, Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Boonsboro, Wash. Co., Md.			
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.				ADDRESS Boonsboro, Md. 21713		25a. DATE REC'D. BY REGISTRAR SEP 22 1980		25b. REGISTRAR'S SIGNATURE <u>Robert McBrady</u>	

October 1, 1901

Washington

Dear Sirs

Yours truly

W. J. Fox

Washington

W. J. Fox

W. J. Fox

W. J. Fox

Charles

No

Washington, D. C.

9-23-01

Garfield

1898

Washington, D. C.

TO HOSPITAL/ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M
(VRA 15, 4) 1/79

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 4 3 5 5			
1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Russell Cornelius Smith				2a. DATE OF DEATH MONTH DAY YEAR Sept. 18, 1980		2b. HOUR 5:25 A M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR FEB. 24, 1898		6 AGE (IN YEARS LAST BIRTHDAY) 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Bark Hill, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Guard		12b. KIND OF BUSINESS OR INDUSTRY U. S. Gov.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro		13e. STREET ADDRESS 120 Orchard Dr.	
14 FATHER'S NAME John Nelson Smith				15. MOTHER'S MAIDEN NAME Martha Georganna Myers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W. W. One 217-42-8168		17 INFORMANT ADDRESS Mrs. Lorraine Gilbert, Rfd. 1 Box 2 Boonsboro, Md. 21713			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Ascaricardiac of long standing 1533 DUE TO, OR AS A CONSEQUENCE OF (b) with extensive hard and fibrous metastases DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 year							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-17 , 19 67 , to 8-17- , 19 80 , that (I) (we) last saw the deceased alive on 8-17- , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE St. J. Smith		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-18-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH SECONDARI				22e. ADDRESS Boonsboro 21713			
23a. BURIAL, CREMATION, REMOVAL ISP Burial		23b. DATE 9-20-80		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION Boonsboro, Wash. Co., Md.	
24 FUNERAL DIRECTOR NAME John H. Bast, Jr. ADDRESS Boonsboro, Md. 21713				25a. DATE REC'D. BY REGISTRAR SEP 22 1980		25b. REGISTRAR'S SIGNATURE L. J. H. Bast	

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Journal of Management Education 31(1)

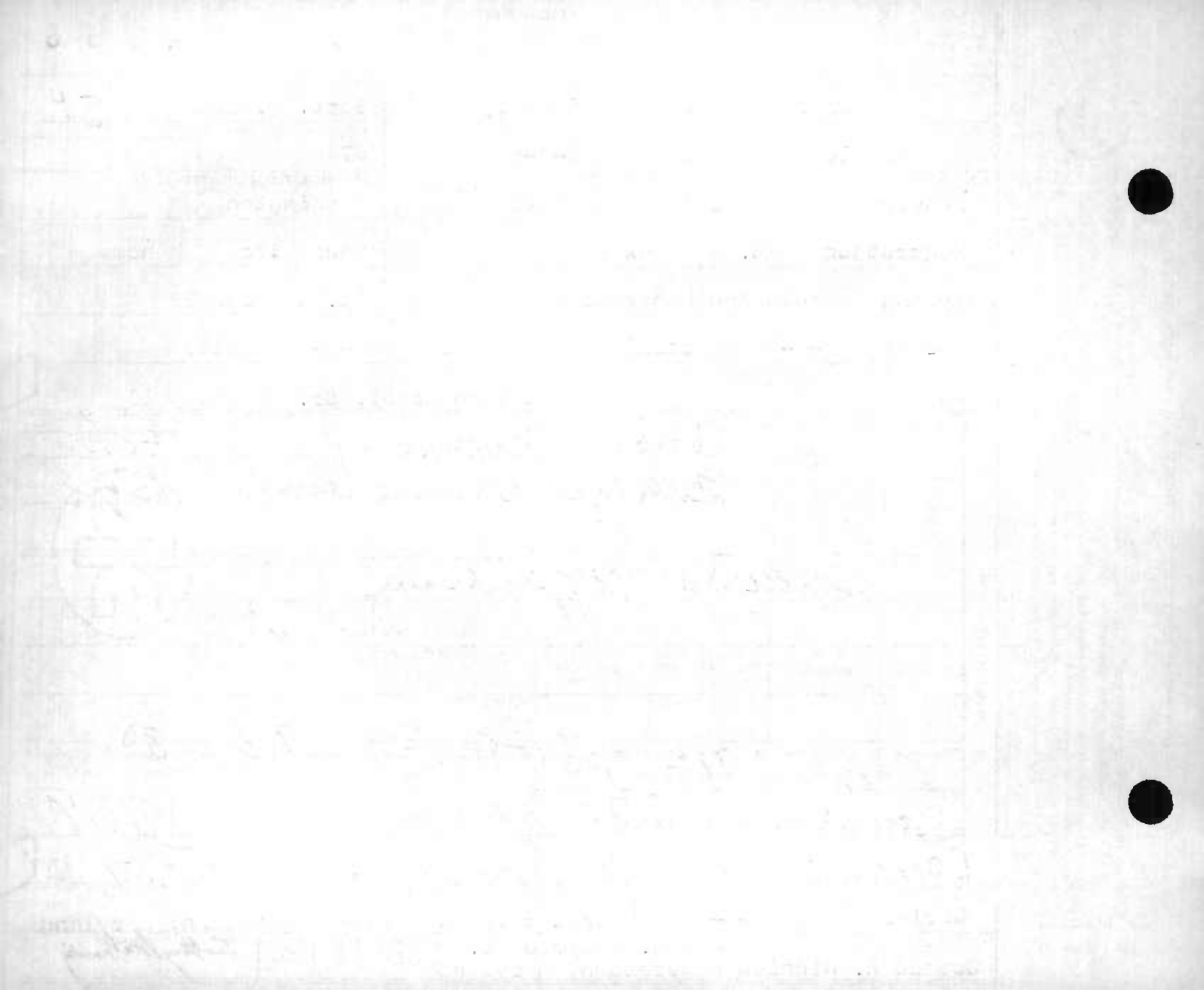
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 4 3 5 6
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR	
Klara Sokol (Szakal)		Sept. 3, 1980	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)
Female	White	8-8-93	87
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Hungray	USA		Washington MD
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Hagerstown	Rt. 4 Box 73		housewife
12b. KIND OF BUSINESS OR INDUSTRY		12c. HOME	
home			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Maryland	Washington	Hagerstown	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
John - - Bercellie		Klara - - Bollo	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS	
no		Joseph Sokol, Sr. see # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 4340 DUE TO OR AS A CONSEQUENCE OF (b) Diabetes atherosclerosis 1540 + DUE TO OR AS A CONSEQUENCE OF (c) Essential Hypertension 4340			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
Essential Hypertension			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/2 1980 to 9/3 1980, that (I) (we) lost saw the deceased alive on 9/2 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE	22c. DATE SIGNED	22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)	22f. ADDRESS		
DONALD E. MANTON M.D.	363 S. Cleveland Ave. Hagerstown, Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	9-6-80	Rest Haven Cemetery	Hagerstown, Maryland
24. FUNERAL DIRECTOR NAME		25. DATE REG'D. BY REGISTRAR	
Gerald N. Minnich Hagerstown, Maryland		SEP 11 1980	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



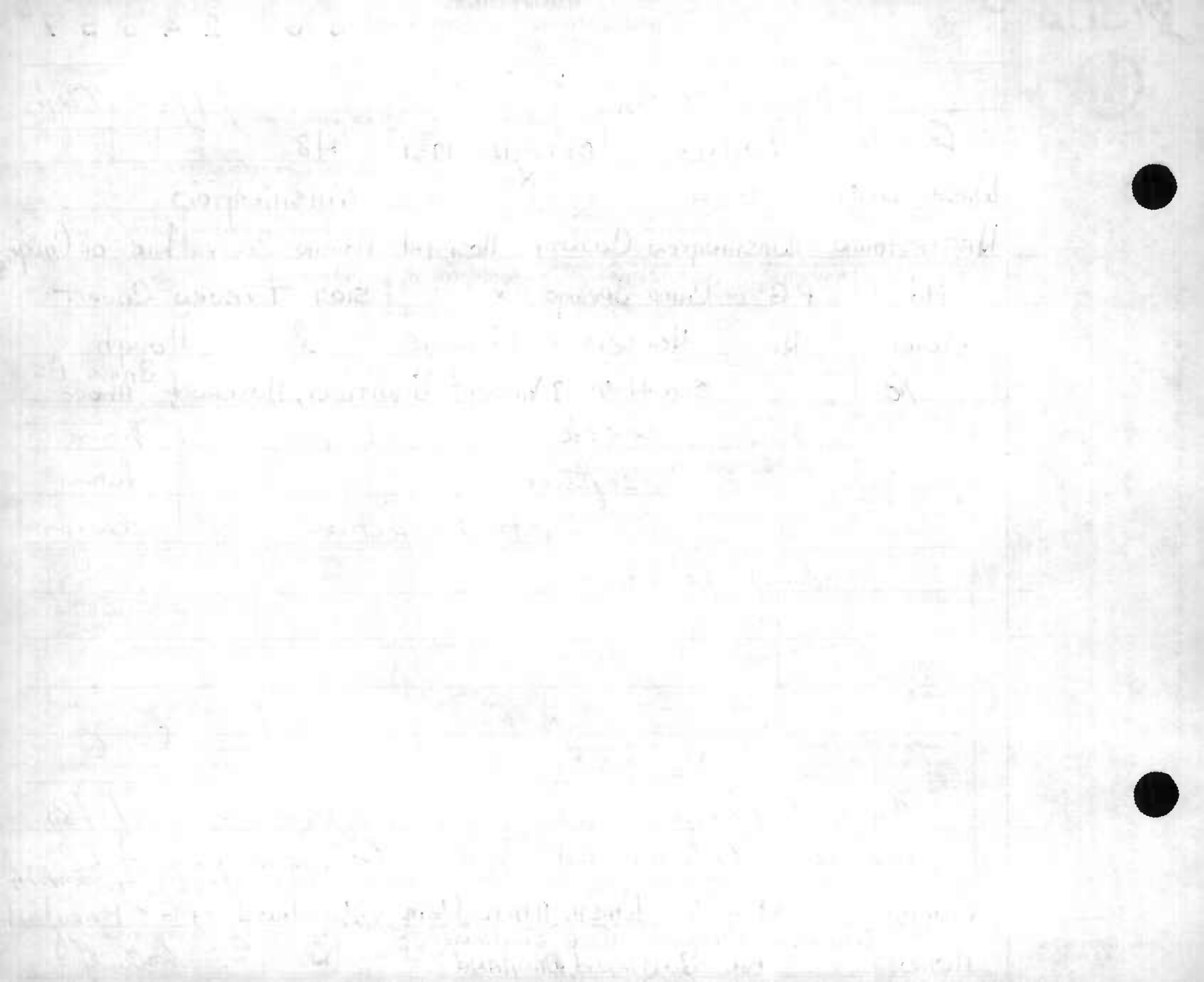
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	2	4	3	5	7
1- FOR STATE REGISTRAR										REG. NO.						
1 DECEASED NAME (TYPE OR PRINT) PATRICIA HOLDEN SQUITIERI										2a DATE OF DEATH 9/1/80				2b HOUR 7:10 PM		
3 SEX Female			4 RACE WHITE		5 DATE OF BIRTH OCT. 12 1931			6 AGE (IN YEARS LAST BIRTHDAY) 48		7 UNDER 1 YEAR MONTHS 0 DAYS 0		8 UNDER 2 YRS. HOURS 0 MIN 0				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C.			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD								
10 CITY OR TOWN OF DEATH HAGERSTOWN			11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON COUNTY HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Admin. Sec'y.			12b KIND OF BUSINESS OR INDUSTRY LIB. OF CONGRESS						
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md 13b CITY PG Camp Springs										13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS 5107 TYBURN COURT				
14 FATHER'S NAME JOHN H. HOLDEN					15 MOTHER'S MAIDEN NAME GEORGIE E. Hough					16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 350-44-7779			
17 INFORMANT Vincent Squitieri, Husband										18 ADDRESS Same As Above						
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) shock										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours						
5990 DUE TO, OR AS A CONSEQUENCE OF (b) septicemia										hours						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) urinary tract infection										days						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Subdural hematoma																
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/31/80				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22 I certify that (I) (this hospital) attended the deceased from 8/31/80 to 9/1/80 , that (I) (we) lost the deceased alive on 8/31/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b SIGNATURE Flora P. Palomo MD										DEGREE		22c DATE SIGNED 9/1/80				
22d PHYSICIAN'S NAME (TYPE OR PRINT) Flora P. Palomo MD										22e ADDRESS 1500 Pennsylvania Ave NW						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b DATE 9-4-80		23c NAME OF CEMETERY OR CREMATORY WASH. NATL. CEM.				23d LOCATION (CITY OR TOWN) SUITLAND PG COUNTY STATE MARYLAND						
24 FUNERAL DIRECTOR NAME Wilhelm Funeral Home				ADDRESS 4308 Suitland Rd. Suitland Maryland				DATE REC'D. BY REGISTRAR SEP 4 9 1980		REGISTRAR'S SIGNATURE Patricia K. Kelly						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	2	4	3	5	8
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Charles Edgar Stottlemeyer, Jr.										2a. DATE OF DEATH MONTH DAY YEAR September 16, 1980				2b. HOUR M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 13, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.										
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 102 Fairground Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY Aircraft								
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 102 Fairground Avenue								
14. FATHER'S NAME Charles Edgar Stottlemeyer				15. MOTHER'S MAIDEN NAME Delta P. Hann												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-7833		17. INFORMANT ADDRESS Delta P. Stottlemeyer, 102 Fairground												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute respiratory failure</u> 496- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardiac disease - Hypertension</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerotic cardiac disease - Hypertension</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (1) (myself or another) attended the deceased from <u>31 March</u> , 19 <u>57</u> , to <u>Date</u> , 19 <u>80</u> , that (1) <u>XX</u> last saw the deceased alive on <u>15 Sept.</u> , 19 <u>80</u> , and that in (my) <u>X</u> opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (not) view the body after death.										22c. DATE SIGNED 17 Sept., 80						
22b. SIGNATURE <u>Richard T. Binford</u>				22e. ADDRESS 1135 Potomac Avenue Hagerstown, MD 21740												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-18-80		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION Hagerstown, Wash., Md.										
24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hag.,				25a. DATE RECD BY REG. CLERK SEP 22 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>										



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	2	4	3	5	9
1 - FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Maria - - Suranno										2a. DATE OF DEATH MONTH DAY YEAR Sept. 4, 1980				2b. HOUR 4:30 AM		
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1-15-90		6 AGE (IN YEARS LAST BIRTHDAY) 90		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? Italy		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.										
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 318 S. Potomac St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY home								
13a. STATE Maryland										13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 318 S. Potomac St.		
14. FATHER'S NAME FIRST MIDDLE LAST Antonio - - Mitrone				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angelina - - LaRose												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 10 6877		17. INFORMANT Rose Mazzo		ADDRESS see # 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchiopneumonia</u> 4409 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 day						
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>4/8</u> 19 <u>80</u> to <u>9/4</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9/1</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Robert Vh Campbell MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/5/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robt Vh Campbell				22e. ADDRESS Hagerstown MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-6-80		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Maryland										
24. FUNERAL DIRECTOR NAME Gerald N. Minnich				305 N. Potomac St. Hagerstown, Maryland		SEP 15 1980		25. REGISTRAR'S SIGNATURE								

(M)

[Faint, illegible text and markings covering the page, possibly bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 4 3 6 0			
1. FOR STATE see 18c REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Towice mae Swain				2a DATE OF DEATH MONTH DAY YEAR 9 2 80		2b HOUR 3:45 P M	
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR November 3, 1924		6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10 CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerk		12b KIND OF BUSINESS OR INDUSTRY News Dist.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b STREET ADDRESS 225 South Locust Street	
13a STATE Maryland		13b COUNTY Washington		13c CITY OR TOWN Hagerstown			
14 FATHER'S NAME FIRST MIDDLE LAST Glenn L. Martin				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alta J. Kinsey			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 219-12-1492		17 INFORMANT ADDRESS Leonard N. Swain, Hagerstown, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Preleukemic Disorder				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo			
2028 } DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Alkylating Agent therapy 10 yrs							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) her pre-leukemic disorder may be secondary to chronic Cytosan therapy which she received for a malignant lymphoma							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Feb 80		21f LOCATION CITY OR TOWN Sept 2 19 80 COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from Sept 2 19 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Frederic H. Koss III		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 9/2/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Frederic H. Koss III		22e ADDRESS 1825 Howell Rd, Hagerstown Md					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE Sept. 5, 1980		23c NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d LOCATION CITY OR TOWN Hagerstown, Wash., COUNTY STATE Maryland	
24 FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 435 E. Wilson Blvd., Hagerstown, Maryland 21740				25a DATE REC'D. BY REGISTRAR SEP 8 1980		25b REGISTRAR'S SIGNATURE Anthony McCreedy	



Johns Hopkins University

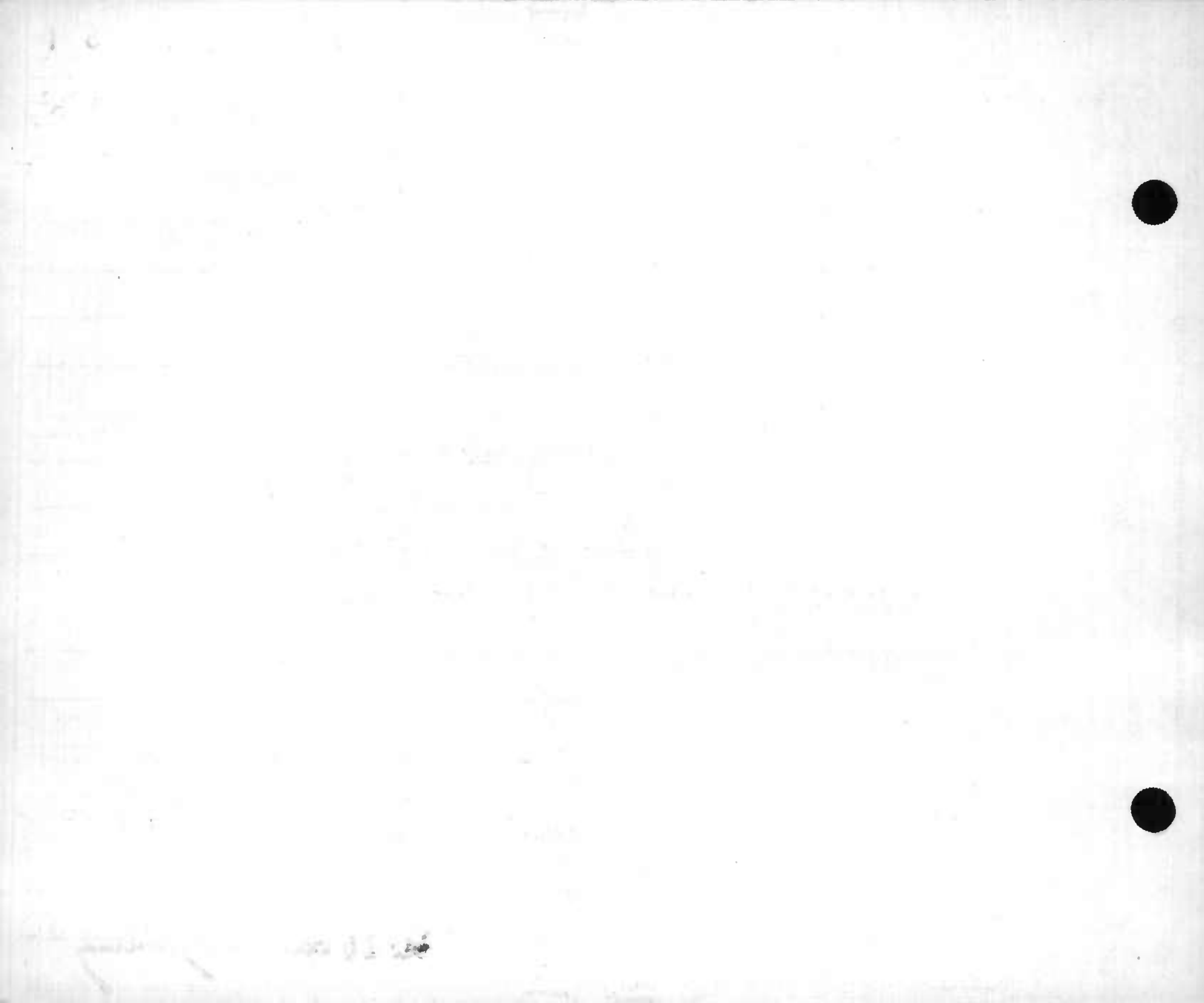
Department of Medicine
The Johns Hopkins Hospital
Baltimore, Maryland

Feb 10 1900
[Signature]
[Signature]
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	2	4	3	6	1
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Heather Ann Talbert</i>										2a. DATE OF DEATH MONTH DAY YEAR <i>9/3/80</i>				2b. HOUR <i>4:30</i> M		
3. SEX <i>Female</i>			4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>9 3 80</i>			6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>9 2 24</i>			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Hagerstown Md.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.							
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Co. Hospital</i>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>112 N. Potomac Street</i>						
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ronald Talbert</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Jody Ann Gladhill</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>					16b. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Jody Ann Gladhill</i>					ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Distress Syndrome</i> <i>769-</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>lung immaturity</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>marked prematurity + immaturity</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Estimated gestational age 22 weeks.</i>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <i>9-3</i> 19 <i>80</i> , to <i>9-3</i> 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>9-3-80</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22a. SIGNATURE <i>Ronald E. Keyser M.D.</i>					DEGREE <i>7AMP</i>					22c. DATE SIGNED <i>9-3-80</i>						
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Ronald E. Keyser M.D.</i>					22e. ADDRESS <i>138 E. Antietam St. Hagerstown, MD</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>9/6/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown Washington MD</i>								
24. FUNERAL DIRECTOR NAME <i>Osborne Funeral Home</i>					ADDRESS <i>Wmospot, MD</i>			25. PREPARED BY <i>SEP 30 1980</i>		25. REGISTRAR'S SIGNATURE <i>[Signature]</i>						



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 4 3 6 2											
1. FOR STATE REGISTRAR				REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) Leroy Irvin Weyant				2a. DATE OF DEATH MONTH DAY YEAR 9-18-80		2b. HOUR 4:42 PM									
3. SEX male		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 5 14 33		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS. <table border="1"><tr><td>MONTHS</td><td>DAYS</td><td>HOURS</td><td>MIN</td></tr><tr><td></td><td></td><td></td><td></td></tr></table>		MONTHS	DAYS	HOURS	MIN				
MONTHS	DAYS	HOURS	MIN												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.									
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Mem Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Pa				13b. COUNTY Huntington		13c. CITY OR TOWN Burnt Cabins									
14. FATHER'S NAME FIRST MIDDLE LAST Ralph Weyant				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Pebley											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO 211 26 0785		17. INFORMANT ADDRESS Carol Weyant Burnt Cabins, Pa.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1629 Cardio-Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Lung DUE TO, OR AS A CONSEQUENCE OF (c) 															
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22. I certify that (I) (this hospital) attended the deceased from 8-21-80 , 19 80 , to 9-18-80 , 19 80 , that (I) (we) last saw the deceased alive on 9-18-80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
23a. SIGNATURE Eric M. Wagshal DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		23c. DATE SIGNED 9-18-80									
24. PHYSICIAN'S NAME (TYPE OR PRINT) Eric M. Wagshal M.D.				25. ADDRESS 1825 Howell Road, Hagerstown, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 22-80		23c. NAME OF CEMETERY OR CREMATORY Pleasantville Cemetery West St. Clair, Bedford, Pa.		23d. LOCATION CITY OR TOWN COUNTY STATE									
24. FUNERAL DIRECTOR NAME ADDRESS A.K. Coffman Funeral Home, Inc., Hagerstown, Md.				25. DECEASED BY REGISTRAR OR REGISTRAR'S SIGNATURE SEP 21 1980											

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Washington

Travel

all records

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 4 3 6 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Dawson Emmanuel Wills				2a. DATE OF DEATH MONTH DAY YEAR September 15, 1980		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 17, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clearview Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Musician		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown	
14. FATHER'S NAME FIRST MIDDLE LAST Alfred W. Wills				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Betts			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-30-8600		17. INFORMANT ADDRESS 33 Tara Road Victor H. Wills, Phila., Penna. 19154			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> (c) <u>Atherosclerosis</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 19 80</u> to <u>Sept 15 80</u> , that (I) (we) last saw the deceased alive on <u>Sept 19 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>J. D. Wilson, M.D.</u>				DEGREE MD		22c. DATE SIGNED 9/16/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. D. Wilson, M.D.				22e. ADDRESS 580 Northern Ave., Nags. MD 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-19-80		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery Hagerstown, Wash., Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hag., Md.				25. PREPARED BY SEPT 22 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 01-10-01 BY 1043

1. The first part of the document discusses the importance of maintaining accurate records of all activities. It emphasizes that without proper documentation, it is difficult to track progress and identify areas for improvement.

2. The second part of the document describes the various methods used to collect and analyze data. It mentions that a combination of qualitative and quantitative techniques was employed to ensure a comprehensive understanding of the subject matter.

3. The third part of the document presents the findings of the study. It shows that there is a significant correlation between the variables being studied, which supports the hypothesis that was initially proposed.

4. The final part of the document offers conclusions and recommendations based on the results. It suggests that further research is needed to explore the underlying mechanisms and to test the findings in a larger, more diverse sample.